



Anglia Ruskin
University

BEFRIENDING PROGRAMME

FINAL REPORT: EVALUATION FRAMEWORK DEVELOPMENT PROJECT

This is the final report of the Evaluation Framework Development Project. The project ran from March-July 2017. It involved a research team from Anglia Ruskin University facilitating the co-production of an evaluation framework with the providers in the Befriending Programme and Essex County Council.

Dr Claire Preston and Dr Sarah Burch
claire.preston@anglia.ac.uk, sarah.burch@anglia.ac.uk,

Acknowledgements

Funding for this project came from Essex County Council.

We would like to thank Essex County Council, Age UK Essex, Colchester Community Voluntary Services, Royal Association for Deaf People, Support for Sight, Age Concern Southend-on-Sea, West Essex Mind, and Action for Family Carers. Representatives from these organisations attended the workshops or took part in the interviews which formed part of the research process. We would also like to thank members of the Older People's Research Group (Essex) and the two Community Agents who agreed to be interviewed for the project. Finally, we would like to thank Ruth U'Ren who was enrolled on the Anglia Ruskin Research Internship Programme 2017. Ruth provided very useful support in the analysis of findings and writing up of the research.

The research team

Dr Sarah Burch is the Director of Research and Scholarship in the Faculty of Health, Social Care and Education in Anglia Ruskin University. In her current role, she oversees a diverse portfolio of research within the faculty, alongside managing provision for doctoral students. Prior to this, she was Head of Department for Family and Community Studies, which delivered primarily Social Work and Social Policy education across three campuses. Sarah's principal research focus is on older people's wellbeing. Her recent research has looked at older people's use of internet-enabled cognitive behavioural therapy, which was presented at the Aging & Society international conference in Sweden in October 2016. Previous research has focused on a range of areas, including rehabilitation for older people in hospital and community settings, methodological concerns in interviewing older people, evaluations of healthy living initiatives and volunteer schemes, and work in different fields, such as children not in education, employment or training.

Dr Claire Preston is a Research Fellow in the Faculty of Health Social Care and Education at Anglia Ruskin University. She recently completed a major mixed-methods *Evaluation of the Silver Line Phonenumber*, launched by Esther Rantzen to tackle loneliness in older people. Its findings have been widely presented in the media, at various high-profile research/practitioner events and featured in AgeUK's December 2016 report *No One Should Have No One*. During 2015, Claire also conducted an evaluation of a Dementia Buddies scheme, operating in a hospital in Essex, which was funded by the South Essex Partnership University NHS Foundation Trust. Claire completed her PhD in 2013, bringing together the disciplines of social policy and social psychology to understand how carers, older and disabled people engage in social care policymaking via the internet.

Corresponding author

Dr Claire Preston
Research Fellow
Faculty of Health, Social Care & Education
Anglia Ruskin University
Young Street Site
East Road
Cambridge CB1 1PT
0845 1962561

EXECUTIVE SUMMARY

Essex County Council (ECC) commissioned Anglia Ruskin University (ARU) to undertake this project between 10 March and 31 July 2017. The primary objective was to enable providers in the Befriending Programme to carry out evaluation of their services themselves in such a way as to allow collation and comparison of the resulting information and data. ARU's central role in achieving this was to facilitate providers and ECC to co-produce a robust and sustainable evaluation framework which all providers were happy to use in their particular work settings.

At the start of the project, ARU hosted a workshop in which representatives from seven providers and ECC co-produced an initial framework. This was then trialled by six providers for a four week period. After a second and final workshop, the following framework was produced. The detailed questions the framework entails are shown in Appendix 1.

Administrative data	<ul style="list-style-type: none">• Client ID• Date data recorded• Referral data
Demographic data	<ul style="list-style-type: none">• Gender• Date of birth• Area of residence
Key contributory facts	<ul style="list-style-type: none">• Key factors association with outcomes eg disability/long-term illness
Outcome 1: loneliness	<ul style="list-style-type: none">• Measured at baseline and subsequent time intervals by scale agreed among providers
Outcome 2: social interaction	<ul style="list-style-type: none">• As for outcome 1
Outcome 3: quality of life	<ul style="list-style-type: none">• As for outcome 1
Outcome 4: client view of what has been useful	<ul style="list-style-type: none">• At end of process, client asked 2 set questions reflecting on what has been useful
Outcome 5: provider comments on client experience	<ul style="list-style-type: none">• At end of process, provider identifies 3 factors capturing client experience of service
Case studies	<ul style="list-style-type: none">• For selected clients, to illustrate the challenges they face and the benefits the service has brought them

Benefits of a co-produced evaluation framework

- The framework suits a range of organisations since it combines core outcomes measures with customisable supplementary information
- Co-producing the framework avoids providers feeling that evaluation is 'done to' them and promotes the feeling that it is done with and by them. ARU's role as an independent third party facilitated this

- The framework is oriented to the Befriending Programme but could be adapted for use in other situations where a mix of providers is working together to address a complex problem
- It formalises and standardises the collection of outcomes data on sensitive subjects such as loneliness and social isolation
- Uniform recording enables clients to be tracked if and when they move between providers. Their current situation can also be more easily compared to how it was at baseline
- The framework includes additional outcomes data which captures the clients' voice and enables providers to identify circumstances particular to individual clients
- The framework enables a good understanding of the way in which befriending services can benefit people who use them. However, it also illustrates the complex web of challenges that many older people face and the consequent need to temper expectations of the improvements that interventions such as befriending might bring

Needs of people using befriending services

Trialling of the framework produced a snapshot of the needs of people using the befriending services. Data on 25 clients was gathered and a deeper understanding of client needs was gained from seven interviews with representatives from six provider organisations. It showed that:

- Older people using the befriending services were suffering from loneliness, social isolation and low quality of life
- These needs combined with other underlying challenges such as poor health to create a complex web of inter-connected problems
- Befriending provision can be useful both in its own right and also a route to identifying and tackling associated problems
- Being a befriender can also bring various rewards to volunteers

Working together to tackle loneliness and social isolation

Collaboration was involved both in co-producing the evaluation framework and in the befriending programme itself. The project showed that this entailed a mix of benefits and challenges:

- The diversity brought by a befriending programme comprising a network of providers produces a flexible set of options for older people
- Network provision of befriending depends on a well-functioning referral system and striking the right balance between Essex-wide provision of some services and localised provision of others
- Collaborating over the evaluation and in the befriending project helped identify gaps in befriending service provision and in underlying services such as transport
- It also highlighted the incidence of dementia among many people accessing services and the potential benefits of recording this more systematically
- Providers understand the collaborative advantage they gain from sharing knowledge, expertise and resources. At the same time, a competitive environment produces tensions over attracting and retaining clients and volunteers
- This might be countered by ECC recognising cross referrals as an outcome and encouraging consortium bids in commissioning

CONTENTS

Acknowledgements.....	1
The research team	1
EXECUTIVE SUMMARY	2
Benefits of a co-produced evaluation framework.....	2
Needs of people using befriending services	3
Working together to tackle loneliness and social isolation	3
CONTENTS.....	4
1: CONTEXT	6
2: THE EVALUATION FRAMEWORK PROJECT	7
2.1 Project objectives.....	7
2.2 Research design	7
2.2.1 Methodology.....	7
2.2.2 Research phases.....	8
3: THE EVALUATION FRAMEWORK	10
3.1 Components of the framework.....	11
3.1.1 Administrative and demographic data	11
3.1.2 Key contributory factors	11
3.1.3 Outcomes measures 1-3	11
3.1.4 Outcome measure 4: client view on what has been useful.....	11
3.1.5 Outcome measure 5: provider comments on client experience	11
3.1.6 Case studies	12
3.2 Collecting outcomes data on sensitive subjects	12
3.2.1 The process of gathering quantitative data: enablers	12
3.2.2 The process of gathering quantitative data: challenges	14
3.2.3 The resulting data: benefits	16
3.2.4 The resulting data: limitations	17
3.3 Reflections on the framework after trialling	18
3.3.1 Additional questions to capture outcomes and client voice	18
3.3.2 What success looks like.....	19
3.3.3 How to capture benefit to volunteers	19
3.4 Conclusions	20
4: NEEDS OF PEOPLE ACCESSING THE BEFRIENDING SERVICES.....	21
4.1 Who accesses services?	21

4.2 Needs of service users	23
4.2.1 Loneliness.....	23
4.2.2 Social isolation	25
4.2.3 Quality of life.....	26
4.3 A picture of complex needs	26
4.4 Meeting needs	27
4.5 Conclusions	30
5: WORKING TOGETHER TO TACKLE LONELINESS AND SOCIAL ISOLATION	31
5.1 A case study in collaborative working: rewards and tensions	31
5.1.1 Joint evaluation as a catalyst for wider collaboration	31
5.1.2 Identifying gaps in provision through collaboration.....	32
5.1.3 The role of referrers.....	32
5.1.4 Tensions over referrals and volunteers	33
5.1.5 Funding regimes affect attitudes to collaboration	34
5.2 Conclusions	34
6: CONCLUSIONS AND RECOMMENDATIONS.....	36
6.1 Conclusions	36
6.2 Recommendations	36
References	37
Appendix 1: Template questionnaire.....	41
Appendix 2: Literature review	44
Appendix 3: Outcomes measures (document circulated to participants).....	48
Appendix 4: Supplementary information and case studies	56

1: CONTEXT

Loneliness and social isolation have been increasingly identified in recent years as a significant problem. Routasalo & Pitkala (2003: 303) state that: “Loneliness may be regarded as a ‘geriatric giant’, leading to impaired quality of life, greater need for institutional care and increased mortality.” The impact of loneliness and social isolation is thus considered in the context of wider concerns relating to use of health and social care services, but any initiatives also need to take into account the aim of giving people greater choice and control over their lives and well-being. The Care Act 2014 placed a number of duties on local authorities, including promoting individual well-being; preventing needs for care and support; promoting integration of care and support; providing information and advice; and promoting diversity and quality in provision of services. Within these broad areas, local authorities are expected to pay particular regard to a number of matters. Particularly relevant are the expectations that they consider: ‘The importance of beginning with the assumption that the individual is best-placed to judge the individual’s well-being’ and ‘the importance of preventing or delaying the development of needs for care and support or needs for support and the importance of reducing needs of either kind that already exist’ (Care Act, 2014: 2).

These considerations are particularly salient for Essex, given that the proportion of older people is greater than the national average for England. In Essex, 19% of the population is over 65, compared with 17% across England (ECC, 2013). In 2015, there were estimated to be 276,529 people aged over 65 in Essex, with a projected increase to 380,179 by 2030 (ECC, 2016). Numbers of older people living alone are growing (ECC, 2013) and it has been reported that only 41.3% of adult social care users have as much social contact as they would like, in comparison with a national figure of 44.8% (ECC, 2016).

However, Essex is very diverse as a county, and there is considerable variation in life expectancy, dementia diagnosis rates, excess winter deaths and health-related quality of life for those with long term conditions (ECC, 2016). Coupled with the differences between rural and urban areas, such diversity means it is difficult to have a single response to loneliness and social isolation or to rely on a single provider. Consequently, the need for different approaches and partners resulted in the implementation of the Befriending Programme. In mid-September 2016, Essex County Council (ECC) announced that as part of its policy to tackle loneliness and social isolation, it had provided £200,000 in grant funding to a group of six third sector providers. The organisations were: Age UK Essex; Colchester Community Voluntary Services; Royal Association for Deaf People (in partnership with Support for Sight and Hearing Help Essex); Age Concern Southend-on-Sea; West Essex Mind; and Action for Family Carers. This new funding built on an earlier project with Age UK Essex and extended the service until March 2018. Under the contract with Age UK Essex, 500 people benefited from befriending provision. The new programme aims to reach 2000 people. In addition to this more ambitious target, the Befriending Programme draws on a wider range of provision, including specialist sensory support, support for carers and training in the use of social media and communications technologies such as Skype.

2: THE EVALUATION FRAMEWORK PROJECT

Essex County Council (ECC) commissioned Anglia Ruskin University (ARU) to undertake this project between 10 March and 31 July 2017.

2.1 Project objectives

The primary objective of the project was to enable providers in the Befriending Programme to carry out evaluation of their services themselves in such a way as to allow collation and comparison of the resulting information and data. ARU's central role in achieving this was to facilitate providers and ECC to co-produce a robust and sustainable evaluation framework which all providers were happy to use in their particular work settings. The idea was that two secondary objectives would also be achieved in the course of providers working together on the primary objective.

Primary objective: Co-production of shared evaluation framework for use by providers

Secondary objectives: Mapping the needs of older people accessing the providers' services;
Fostering collaborative working between the providers

2.2 Research design

Phase 1: Development and framework design
Ethical approval
Background research, review of literature on successful interventions, review of outcomes measures
Informant interviews with 2 Community Agents and 2 members of OPRG
Workshop 1 co-production of initial framework
Phase 2: Data collection and framework testing
Providers collect data using framework over 4 week period
Interviews with providers
Interim report
Phase 3: Analysis, framework revisions, conclusions
Preliminary analysis
Workshop 2 feedback findings and co-revise framework
Final analysis and conclusions
Production and dissemination of final report

2.2.1 Methodology

The research followed an action research methodology (Munn-Giddings and Winter, 2013). This meant that the providers themselves were involved in formulating, testing and revising the evaluation framework. The role of ARU was to facilitate this process and identify the issues which arose from it. This would produce a framework for immediate use and, in addition, identify learning points to inform future adaptations of the framework, as well as other instances of collaboration, either regarding evaluation specifically, or with wider objectives.

2.2.2 Research phases

Phase 1 Development and design of framework

Ethical approval Ethical approval for the project was given by the University ethics board, in accordance with ECC's research governance.

Background research and literature review Desk-based background research included the collection and collation of existing relevant data from providers. This stage also included a review of literature on successful interventions which address loneliness and social isolation in older people and improve their wellbeing. This can be seen in Appendix 2. The ARU research team also sent providers a document proposing and detailing various outcome measures (see Appendix 3). Providers were encouraged to consider this prior to attending Workshop 1. The document offered a choice between two recommended options for each of three Befriending Programme outcomes (loneliness, social interaction, quality of life).

Informant interviews The research team conducted semi-structured interviews with two members of the Older People's Research Group (Essex) and two Community Agents. The purpose of the interviews was to understand the participants' views on the experiences of older people accessing services and support networks, including any particular challenges they face. They also gathered opinions on talking to clients about sensitive subjects such as loneliness and social isolation.

Workshop 1 Ten representatives from seven providers attended Workshop 1, along with three representatives from ECC. During this workshop participants shared best practice, knowledge and expertise to co-produce an initial evaluation framework which six providers then tested during Phase 2. The workshop was recorded and analysed as part of the research process. It also included an opportunity for the providers to discuss particular concerns without representatives from ECC in the room. They were assured that no direct quotes would be used from this section of the workshop in order to protect confidentiality.

Phase 2 Data collection and framework testing

Data collection by providers The providers used the new evaluation framework to gather data about people who joined their services over a four-week period. The data covered demographic details and baseline information on the outcomes measure (loneliness, social isolation, wellbeing), as well as referrals information. Data was submitted in two rounds: the first after two weeks and, the second, at the end of the four week period. The first submission acted as a process check, allowing any difficulties to be addressed. In addition, providers were asked to record up to three initial conversations with clients (having sought their fully informed consent).

Interviews with providers The research team conducted seven semi-structured interviews with representatives from six of the providers. These interviews typically lasted 60 minutes and were recorded. They covered the following topics:

- 'What works' in understanding and addressing loneliness, social isolation and wellbeing among people who use their services
- Enablers and challenges in measuring or recording this information for evaluation purposes

- Enablers and challenges in collaborative working – particularly issues they may not have wanted to raise in the collective setting of the workshop

Interim report to ECC The research team submitted an interim progress report, including presentation of the initial evaluation framework.

Phase 3 Framework revisions, analysis, project conclusions

Workshop 2 Representatives from each of the six providers were invited to attend this workshop. It enabled the researchers and providers to feedback information on the challenges and successes encountered in using the initial framework to gather data and working collaboratively. During these discussions participants revised the evaluation framework in various minor ways.

Analysis and interpretation of data Analysis took place mainly prior to but also after workshop 2. The project produced the following sets of data:

- Transcription of interviews with two members of OPRG and two community agents
- Transcription from workshops 1 and 2
- Information on a total of 25 new clients from six providers
- Two transcriptions of guided interviews from one provider
- Transcriptions from seven interviews with six provider organisations

The researchers collated the data on the 25 clients and summarised it using basic descriptive statistical analysis. The analysis of the guided interviews consisted of an independent assessment by the researchers of what strategies seemed to work well and less well in the process of conducting them.

All other transcriptions were subject to a multi-stage method of inductive thematic coding (Miles and Huberman, 1994). Researchers approached the coding with the research aims in mind, so the focus was on: understanding and responding to the needs of people who use the services, gathering data for evaluations, and collaborative working. The analysis comprised the following steps:

- Researchers familiarised themselves with the data by reading the transcripts – two researchers read each transcript
- They coded the text systematically, line-by-line, with the purpose of organising it into meaningful groups, recording their reflections in memos as they proceeded
- Researchers sorted codes into potential themes in a process of Pattern Coding. During this process, they reviewed and refined the themes in an iterative and reflexive manner
- They identified overarching themes and used these to draw conceptual conclusions from the data

3: THE EVALUATION FRAMEWORK

The principal aim of the project was for ARU to bring providers in the Befriending Programme together with representatives from ECC to co-produce an evaluation framework. The diagram below illustrates the main components of the resulting evaluation framework. The questions it entails are detailed in Appendix 1. The framework combines a core shared set of data about clients with customisable supplementary information. It is oriented to evaluating third sector organisations delivering services to address loneliness and social isolation but the approach could be adapted for use in other situations where a mix of providers is working together to address a complex problem.

Figure 1: Components of the final evaluation framework

Administrative data	<ul style="list-style-type: none"> • Client ID • Date data recorded • Referral data
Demographic data	<ul style="list-style-type: none"> • Gender • Date of birth • Area of residence
Key contributory facts	<ul style="list-style-type: none"> • Key factors association with outcomes eg disability/long-term illness
Outcome 1: loneliness	<ul style="list-style-type: none"> • Measured at baseline and subsequent time intervals by scale agreed among providers
Outcome 2: social interaction	<ul style="list-style-type: none"> • As for outcome 1
Outcome 3: quality of life	<ul style="list-style-type: none"> • As for outcome 1
Outcome 4: client view of what has been useful	<ul style="list-style-type: none"> • At end of process, client asked 2 set questions reflecting on what has been useful
Outcome 5: provider comments on client experience	<ul style="list-style-type: none"> • At end of process, provider identifies 3 factors capturing client experience of service
Case studies	<ul style="list-style-type: none"> • For selected clients to illustrate the challenges they face and the benefits the service has brought them

3.1 Components of the framework

This framework is designed to collect basic information on all new clients, including baseline outcomes data. Outcomes data can then be collected after agreed time intervals and compared to baseline data to give a sense of clients' progress over time. The information for the framework should be collected at the initial meeting, either through a guided conversation format or in a more discrete survey carried out at the end of an informal introductory conversation. The wording of outcomes questions 1-3, in particular, should be altered as little as possible so as to maintain the comparability of responses.

3.1.1 Administrative and demographic data

The framework enables providers to record basic administrative and demographic data in the same format to facilitate comparison. Other data (eg on ethnicity) might also be included as standard. Referrals data is also included and should be collected to reflect both referrals by providers on to other services within their own organisation as well as those to other organisations. When providers receive referrals, it should also be recorded where these have come from.

3.1.2 Key contributory factors

This information can be ascertained from referral information or from initial conversation with the client. Factors that may be included are those known to be associated with the outcomes. In this project, a single factor was included, which was whether the person has a long-standing illness or disability. This was asked using a question from the English Longitudinal Study of Ageing. Other factors to consider in regard to an outcome of loneliness/social isolation are: bereavement, living alone, presence of dementia, lack of adequate transport. The final set of factors to include can be agreed on a per project basis.

3.1.3 Outcomes measures 1-3

The outcome measures can be agreed on a per project basis. The sets of questions agreed by participants in this project are detailed in Appendix 1. These or other outcomes measures can be used in future applications of the framework. These questions are asked at baseline and at subsequent agreed time intervals.

3.1.4 Outcome measure 4: client view on what has been useful

At the point when the client moves out of the provider's service or on to another service, the provider asks them two set questions to reflect on their experience. The questions agreed for this project are listed in Appendix 1.

3.1.5 Outcome measure 5: provider comments on client experience

At the point when the client moves out of the provider's service or on to another service, the provider completes a comment box using their own words to reflect on the client's experience of the service. This enables them to provide information not captured by other outcomes, for example that the client has now joined a local community group or that they appear to be much more self-confident. The comment box has a restricted word count but enables the provider to make 3 key points.

3.1.6 Case studies

The framework includes the facility for providers to submit detailed case studies on a small number of clients. Participants in this project underlined the value of case studies in bringing quantitative data to life and encouraging a more rounded understanding of outcomes such as loneliness and social interaction than that gained from set measures alone. Case studies submitted as part of this project can be seen in Appendix 4.

3.2 Collecting outcomes data on sensitive subjects

The central issue in agreeing the initial evaluation framework was the question of how to gather outcomes data. In this project, the aim was to gather quantitative data from older people on the potentially sensitive subjects of loneliness, social interaction and quality of life. In workshop 1, it became clear that many providers felt uneasy at the prospect of asking any set questions about these issues. They preferred the idea of covering such issues in general conversation and of demonstrating outcomes by asking clients about their satisfaction with services and by measuring indicators of activity such as client and volunteer numbers. However, other providers were already routinely using set questions to ask clients about outcomes such as their loneliness and social isolation and were prepared to recommend these to others. In this regard, the evaluation framework project was useful as an exercise in sharing best practice.

This section distils the main points the providers made during workshop 1 and the provider interviews about gathering quantitative data on the outcomes. The first sub-section concerns the process of gathering the data and is divided into enablers and challenges. The second sub-section concerns the resulting data and is divided into its benefits and limitations. This information is summarised in Figure 2.

3.2.1 The process of gathering quantitative data: enablers

Guided conversation

There was widespread agreement that ‘guided conversations’ provide a good route for gathering quantitative data on issues such as loneliness. This technique of sandwiching survey questions between segments of informal conversation strikes the right balance between sensitivity and reliability.

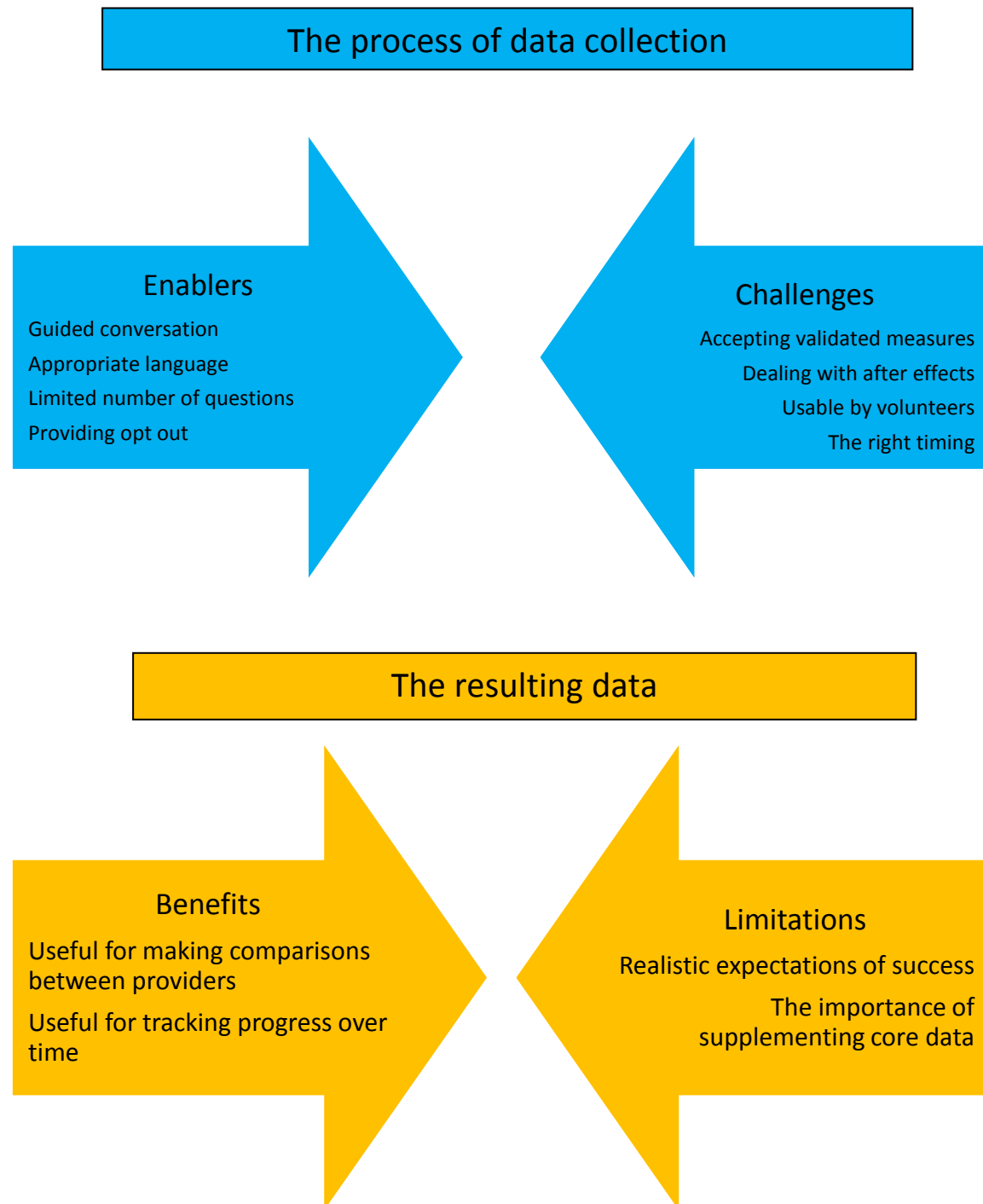
“If it’s done as a semi-structured interview, which is the way we use it, it stops feeling like you’re filling in a scoresheet.” (Provider 1, workshop 1)

However, getting the balance right is not always easy in practice, as this comment testifies:

“Most of the people I asked, they were happy to answer the questions, and some of the people had very nice conversations about it. I think to start with, I wasn’t quite sure how to do it. I did explain, “We’re doing some research, would you mind answering some questions?” and did it, literally asked them the questions. But then some people, I tried to make it more in the conversation, although I did explain that still, it then became more of a conversation. (Provider 3, interview)

Clearly, it is preferable if the general conversation does not blur into the survey questions and result in changing the wording of questions so that a different question is, in effect, being asked of different people. This can intentionally or unintentionally lead people to particular answers and so diminishes the reliability and comparability of the answers. Some surveys provide a form of words to preface questions, for example: "These questions are about how you feel about different aspects of your life. For each one please say whether you agree strongly, agree etc." Using this kind of phraseology can be useful to signal the move from general conversation to survey questions.

Figure 2: Collecting outcomes data on sensitive subjects



Appropriate language

Representatives from the providers working with visually and hearing impaired people drew attention to the need for appropriate language in survey questions. For example, one provider explained:

"I think the questions about chatting on the phone, I mean, obviously for deaf people that's just not an option, is it, so that would definitely have to be changed." (Provider 11, workshop 1)

In this project, questions were reworded to overcome these problems. There was also concern among providers about using appropriate language both due to the sensitivity of the subject matter and the challenges clients might face:

"For some of the target audience - hearing loss, slight dementia, in their 80s - it's a tough one to do." (Provider 6, interview)

In this respect, validated scales can help because they have at least been tested on wide and varied populations.

Limited number of questions

It was generally agreed that older people should not be burdened with a large number of questions, yet at the same time, it was seen as preferable to use more than one outcome measure in evaluating a service. For this reason, lengthier scales were rejected in favour of shorter ones.

"It's really easy to administer those measures. It's one side of A4. It's a little question that you do when you have your initial chat with someone, and then you can do three months down the line and look at any movement. It's not onerous." (Provider 1, interview)

"The way we use it ourselves, it's one sheet and you tell people, "We're going to ask you some questions so we can check out how you are now, and then in a couple of months your befriender will ask you them again, just to see how things are for you then." (Provider 2, interview)

Providing opt out

A key step in conducting any survey in an ethical manner is to tell the person answering the questions that they are not obliged to respond to any particular question if they would rather not. It was clear from the providers' data from that, for the most part, people were happy to answer the questions but gaps in the data also demonstrate that providers were indeed giving people the chance to opt out.

3.2.2 The process of gathering quantitative data: challenges

Accepting validated measures

A number of providers felt that the wording in the validated scales was inappropriate for the older people they work with:

"I find the questions all very clinical and quite intrusive" (Provider 5, workshop 1)

“Do you lack companionship?” is not something that we’d say, it’s “Do you have friends and family around you? Do you have somebody that you feel you can actually talk to?” It’s about language. (Provider 1, workshop 1)

These misgivings contributed to the decision in workshop 1 to adopt a set of outcome measures for loneliness, social interaction and quality of life which were already being used by one of the providers, rather than the measures the ARU research team recommended. Choosing which measures to use in the evaluation framework was a consensual process and the balance of opinion was in favour of the measures chosen. We drew attention to the disadvantages of this choice, namely that apart from the loneliness questions (which come from the Campaign to End Loneliness), the questions have not been tested and are not comparable with other data sets. Interpreting the responses is therefore difficult. However, on balance, we considered that it was more important to allow the providers to exercise their autonomy than to insist on them using the measures we recommended and risk a resultant lack of buy-in on their part. We felt that acceptance of the principle of using a core set of questions was the greater priority at the time. We recommend however that robust and validated scales are substituted for these questions in future use.

Dealing with the after effects

One of the reasons providers felt uneasy about asking fixed questions about sensitive subjects was the way it might leave people feeling. This might leave volunteers in particular feeling out of their depth.

“I’d be worried about the 20 minutes, the half an hour after you’ve made the call. Think, God, what is that person now thinking about? Because it’s all very well saying, “Yes, I often feel rejected,” or they’ve answered your questions, but actually, once they’ve put the phone down to you, they then might sit there and reflect and actually, they might think, “Do you know what, I don’t have a great life. I’m really empty. I don’t have anyone around me and I feel really rejected.” (Provider 4, workshop 1)

One potential solution is the guided conversation format which includes an explanation at the start that the questions form part of the conversation but there will be an opportunity to revisit any issues raised at the end.

Usable by volunteers

Another issue providers raised was how easy the questions would be for their volunteers to use:

“We want forms to be easy, we need something that our volunteers can actually use as well...because our volunteers do a lot of our monitoring, data capture for us.” (Provider 1, workshop 1)

The issue of how volunteers might deal with people who became upset was also raised:

“If you’ve got someone despairing and in tears because they feel they have no quality of life, what does the volunteer do with it?” (Provider 2, workshop 1)

The right timing

There is a balance between asking new clients questions early enough to obtain baseline information on outcome measures and building a trusting relationship. Some providers expressed concern about this issue:

“When we do a short questionnaire with people, what we’ve found is the timing of when you do that can be key” (Provider 1, workshop 1)

“Once you’ve built rapport, you can get away with possibly more what might be called intrusive questions. Like, “Would you mind me asking, do you live alone?” “Can I ask how many people you talk to during the course of the day?” I wouldn’t do that in the first call or the second call, but once you’re in, you’re in.” (Provider 6, Interview)

Some providers were, however, familiar with collecting baseline outcomes data at first meeting, at least in an informal way:

“When we went out to see a client, we would do what we call an ‘outcomes’ straight away. We would assess how their mood was, how they’re feeling, motivation, everything like that, and then every three months we would do that again.” (Provider 2, interview)

At workshop 2, one issue which was discussed was that when initial contact was made, clients were often unsure who was calling them and for what purpose, especially if they were not aware that a referral had been made. In these circumstances it was suggested that if a client seemed uncomfortable, an appointment could be made to call in a few days’ time to go through the guided conversation itself.

For a shared evaluation framework it is important that all those using it agree whether they will collect baseline data at the first interview or at a subsequent one.

3.2.3 The resulting data: benefits

Useful for making comparisons between providers

Providers are working in a competitive environment where they expect their performance to be compared with that of other providers. In this context, some felt that it was preferable to use standardised outcome measures which enable like-for-like comparisons.

“[It’s] making sure there is some kind of parity in the way we all look at what we’re doing, and whether it’s helpful for people or not. That’s useful, because after an 18-month project to come back and say, “Well, our measurement says we made 40,000 phone calls, therefore we did fantastically,” and “Our measurement says we made X number of visits, which means we did brilliantly.” It’s apples and pears, isn’t it?” (Provider 1, interview)

Providers also acknowledged a need to demonstrate their services are needed and should therefore be funded:

“I do appreciate that in order to get things and get funding, I’ve got to prove that there’s a need and evaluate and make sure it’s working, and if it’s not working, do something different.” (Provider 4, interview)

Useful for tracking progress over time

Providers felt that shared outcomes data was a good way of all organisations involved in a project monitoring progress in a comparable way:

"I think for people who are working on a project, having something to aim for, it's less wishy-washy than, "Oh, just find some befrienders and find some older people and match them up together." This is what we're trying to do, we're trying to improve quality of life for people, befrienders and older people in Essex who are isolated and lonely. The project is about reducing loneliness, how can we check out whether we're actually doing that?" (Provider 1 interview)

"We were very positive about it, we thought that it gave us a good opportunity to show the impact of our services." (Provider 1, workshop 1)

3.2.4 The resulting data: limitations

Realistic expectations

Providers felt that it was important to keep in mind the difficulty of dramatically improving the situation for older people suffering from multiple interconnected problems of which loneliness is just one. The fact that loneliness co-occurs with other challenges, such as mobility issues, poor health and bereavement, is well recognised in research and practice (Holt-Lunstad et al, 2015; Moore and Preston, 2015). Because loneliness is often part of a web of problems, providers felt that funders should have realistic expectations about what might be achieved through a Befriending Programme:

"People within this client category would remain isolated because that isolation is due to their hearing loss. That will still be there, regardless of the intervention that happens around the befriending... so we need to be able to capture that in a way that doesn't show it as being a negative." (Provider 12, workshop 1)

One community agent made a similar point:

"With the population of older people, we know there's going to be a decline, at some point, because they're older people, their health will go down." (Informant 2, interview)

This issue was taken up again in workshop 2 (see section 3.3.2).

The importance of supplementing core data with other quantitative and qualitative data

Providers felt that the core quantitative data gathered in the evaluation framework would not be sufficient to demonstrate the benefits they bring to older people. The most usual recommendation was to use case studies:

"We would do on average most probably four or five case studies a month, and it would be from start to finish, so the person came into service, this is what they wanted, all the way through to they're matched, they're now doing this, they're now doing that." (Provider 2, Interview).

Providers also expressed exasperation with what can become an over-reliance on numbers:

“By talking about numbers and talking about having to provide whatever, and it might be me being completely naïve, but we’re tending sometimes in some places to forget about the actual service.” (Provider 6, workshop 1)

This goes to a wider point about target driven cultures which can result in a situation where proving what is being achieved takes precedence over actually achieving it. This is an important point to bear in mind when designing evaluations or monitoring systems and interpreting the results.

Asked what else apart from case studies might help demonstrate the benefits providers bring, one provider recommended the following:

“I’ve always said, the commissioners, they should come with us. Come out on a visit. Come and see what it is we do, because I can tell you what we do, but I don’t think people really understand. (Provider 2 interview)

This point about outcomes data not necessarily capturing the full picture was taken up again in workshop 2 and led to certain revisions to the framework. These are discussed in the next section.

3.3 Reflections on the framework after trialling

3.3.1 Additional questions to capture outcomes and client voice

Two revisions to the framework were agreed in workshop 2:

- The addition of questions to elicit information from clients on what they found useful in services (Outcome 4 in figure 1)
- The addition of a comment box to enable providers to reflect on the client’s experience of the service (Outcome 5 in figure 1).

Both of these revisions reflected the feelings in workshop 1 and during trialling of the framework that simply asking set ‘before and after’ questions about loneliness, social interaction and quality of life was an inadequate way to fully capture the differences providers’ services could make to people’s lives. There was a feeling that the client voice was lacking from the initial version of the framework and also that providers needed space to explain the particularities of individual’s lives and how that related to their journey through services. For these reasons, two additional items were added to the framework. The first capturing the client’s reflection on their experience of the services and the second capturing additional information the provider felt was important in understanding the client’s experience. These items were formulated in a way that could be shared by providers thereby enhancing the comparability of the data.

The point about widening outcomes also reflected discussion in workshop 2 about the broadness of befriending itself. This issue is covered in Chapter 2 and revisited in Chapter 4.

A notable feature of workshop 2, given various providers’ misgivings about gathering outcomes data was the relative absence of difficulties reported in using the questions on loneliness, social interaction and quality of life. Although there was some discussion of how best to integrate these questions into an initial conversation, there was no move during workshop 2 to revise the questions on loneliness, social interaction and quality of life.

3.3.2 What success looks like

A theme that ran through discussions in workshop 2 was the need to understand what counts as success in tackling loneliness and social isolation among older people. As discussed in section 3.2.4, providers felt that it was important for funders to have realistic expectations about the improvements that befriending can bring, given the numerous challenges many older people face and the losses or setbacks that older people might incidentally experience during the time they are using providers services. Representatives from ECC reassured providers in workshop 2 that preventing a worsening in older people's experience of loneliness and isolation over a period of time can count as a successful outcome. Similarly, an objective of befriending might be to halt someone's slide into a worsening situation following an illness or bereavement, for example. There was also discussion of how the goal of tackling loneliness and social isolation can be seen as part of a wider goal to improve the lives of older people in the face of the multiple challenges they may face:

"It's about having a real life. I think reducing isolation, reducing loneliness, just fits massively into that, so the physical health outcomes, the physical disabilities, hearing and sight loss, dementia, having an enduring physical health problem or mental health problem, they're not all different things, they're all part of the whole of having a meaningful life, despite those disadvantages... reducing isolation, reducing loneliness, is helping people feel loved and feeling part of where they are living." (Provider 2, workshop 2)

3.3.3 How to capture benefit to volunteers

The possibility of adapting the framework to capture the experience of volunteers was another discussion point in workshop 2. Participants agreed that volunteers themselves might experience benefits to their levels of loneliness, social interaction and quality of life from taking part in volunteering. One provider explained this by referring to a particular volunteer who is very active within her organisation:

"She [the volunteer] lives on her own, her husband died when she was in her late 30s, she brought up five kids on her own, the kids have all now left home, so in a way, she's lonely...so she's helping me, but she's helping herself as well." (Provider 1, workshop 2)

The framework could therefore be adapted for use with volunteers themselves. This might entail careful explanation since volunteers may not anticipate at the start of volunteering that it has the potential for making them feel less isolated. One participant pointed out that the reasons volunteers give to explain their motivation at the start of volunteering may not capture what they actually get out of it:

"I've done quite a lot of analysing data on motivations of volunteers over the years, and it is really important to realise that what the volunteers think their initial motivation is, is not actually why they're there to volunteer... You can ask the question, "Why are you here to volunteer?" We all ask that question, but it's only over a period of time that you find out what the real agenda... Nine times out of ten when you first ask that question, they'll say, "I want to give something back to the community." (Provider 7, workshop 2)

Asking volunteers at the start of volunteering why they are volunteering may not therefore be the best way of picking up on the benefits the role can bring in terms of improved social connections or quality of life.

3.4 Conclusions

- The project facilitated the co-production of an evaluation framework. Providers designed, trialled and revised the framework in the course of the project
- The framework combines a core shared set of data with customisable supplementary information. Exact questions are detailed in Appendix 1
- The evaluation framework can be adapted for use in other circumstances, including to assess the benefits to volunteers of volunteering
- Despite the initial reluctance of some providers to ask clients set questions about sensitive subjects such as loneliness, experience trialling the framework persuaded them this was practical and beneficial
- Guided conversations were seen as one way of asking the outcomes questions. Another was to precede formal questions with a friendly informal conversation
- Asking clients about how they felt the service benefitted them was an important component that was added to the framework after trialling
- An open question for providers to comment on how the service benefitted clients was also added after the trialling period
- Expectations of improvements in clients' lives as a result of befriending should be realistic and reflect the numerous and inter-related challenges many older people face

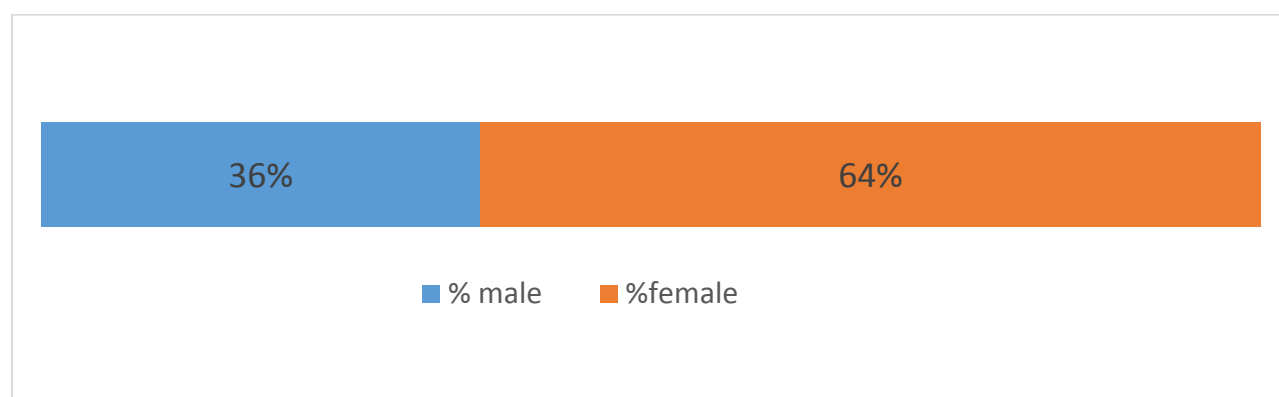
4: NEEDS OF PEOPLE ACCESSING THE BEFRIENDING SERVICES

This section explores the extent to which the evaluation framework identifies information about the needs and characteristics of clients. The quantitative data provides an informative snapshot of the people currently seeking to access befriending provision within a one-month timeframe. The small numbers of clients and narrow timeframe limits the conclusions that can be drawn from this data alone and means the findings may not be generalisable. However the project did reach a deeper understanding of client needs from the interviews the ARU research team conducted with representatives from each provider organisation and with the key informants. These interviews also provide evidence against which to assess the focus of the framework, alongside providing additional information about needs.

4.1 Who accesses services?

As might be expected, more women than men accessed services. Out of the total of 25 respondents, 64% (n=19) were women and 36% (n=6) were men.

Figure 3: Percentage of men and women accessing services (total of 25 respondents)



The age range of respondents ranged from 23-105. Of these, only two were under 50 years old, and the mean age of those over 55 was 81.

There was also a high proportion of people experiencing long term conditions or disability. Out of 25 respondents, 72% reported having long term conditions.

Figure 4: Percentage of people accessing services in each age group (total of 21 respondents)

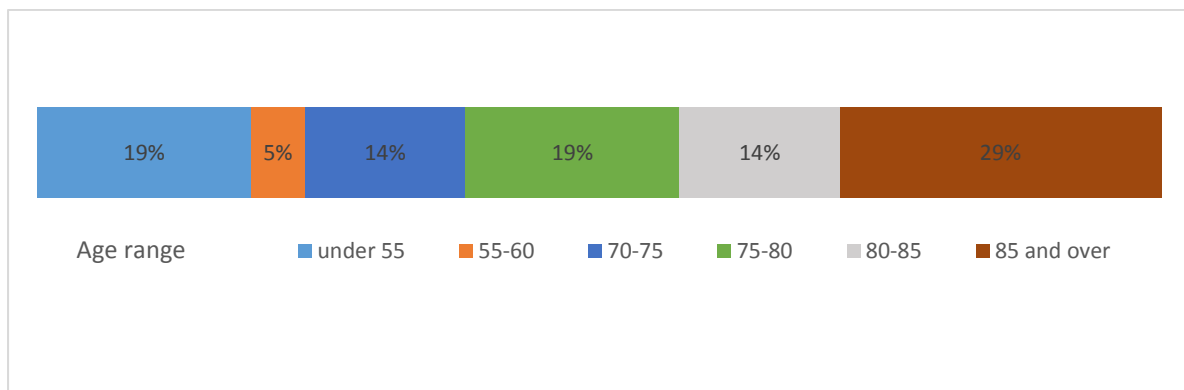
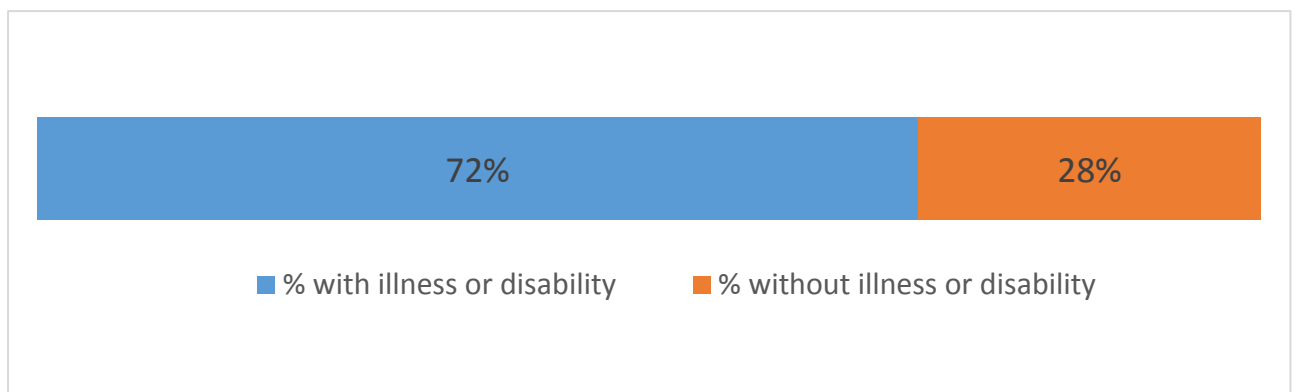


Figure 5: Percentage of people accessing services who have a long-standing illness or disability (total of 25 respondents)



The location of service users can be seen in the map below.

Figure 6: number of people accessing services from locations across Essex



4.2 Needs of service users

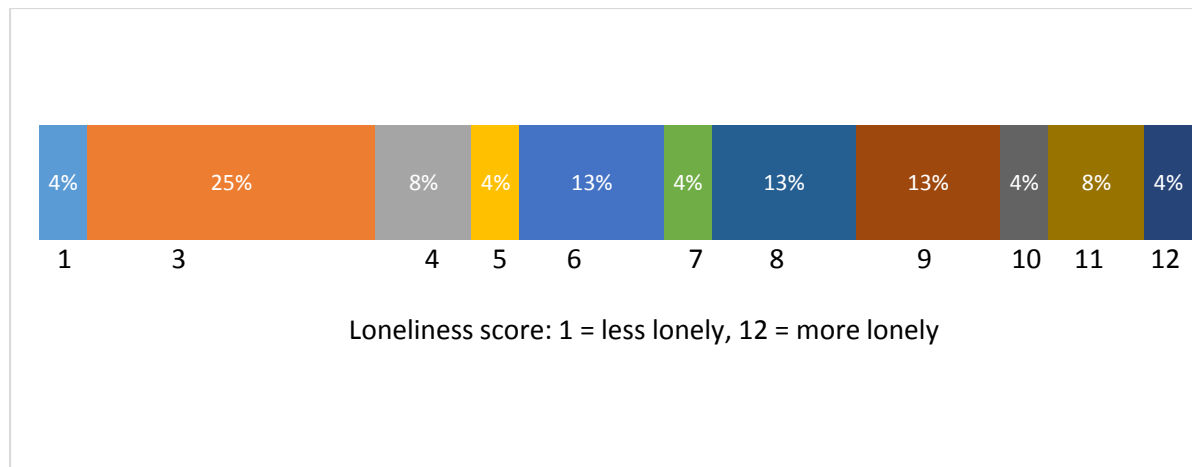
As discussed in chapter 3, the measures selected for the framework focus on loneliness, social isolation and quality of life, hence generating outcome scores. However, this data is also supplemented and enriched by material from interviews with providers and key informants.

4.2.1 Loneliness

Loneliness is a key focus of the evaluation framework given its central role within the objectives of the Befriending Programme. However, findings reflect the notion that loneliness is a complex and variable phenomenon. It is not a uniform experience which can be countered easily by a single intervention.

The range of scores recorded against the loneliness measure (24 out of a possible 25 responses) indicate that the experience of loneliness is diverse (figure 7). While all respondents report a degree of loneliness, this is relatively minor in some cases. One possible contributory factor might simply be the timing of the assessment. At workshop 2, the issue was raised that people may feel less lonely during the day than in the evenings, when there is less activity in their neighbourhoods. This view is supported by research which has found that loneliness for older people can be more acute both in the evenings and in winter (Stanley et al, 2010).

Figure 7: Percentage of respondents who scored each loneliness score - loneliness score is recorded by numbers under the bar (total of 24 respondents)



Findings bear out the idea that loneliness is by no means a given for older people. Loneliness, or lack of it, can be a result of changed circumstances, such as a reduction in social roles and opportunities due to retirement or bereavement (Hawkey et al, 2008), but it can equally stem from personality traits built up over a lifetime of experiences. As one key informant states,

“If you get someone in their 80s, who’s never gone to groups and never been a social butterfly so to speak, then they’re not going to suddenly do that.” (Informant 1, interview)

So identifying a level of loneliness among service users is important, as it avoids the possibility of targeting people with unwanted and unnecessary interventions. Providers gave illustrations of instances where older people were wrongly assumed to want a befriender.

“He says enough to say, ‘I don’t want somebody there.’” (Provider 1, interview)

In contrast, for those who do experience loneliness, the feelings can be acutely painful.

Identifying perceived causes of loneliness can be important as it enables appropriate responses. Sometimes a service-based response may be necessary, but at other times it may simply be that action by services is required to prompt change rather than deliver provision. For example, one key informant stated that mobilisation can be used to overcome the fact that current communities can be quite insular in design,

“If I have one street and I’ve got three or four clients and they’ve all got the same problems, they’re all lonely. I will actually go to one of them, I’ll say, “Well, did you know? There’s a guy that lives 12 doors up from you and he’s in exactly the same boat. Would you mind me giving him your details and then maybe you two meet up for a coffee? Oh, and there’s so-and-so, she lives just round the corner. Why don’t you start...you all go to your house one week, then you go to...” I said, “It’s all within 100 yards of each other.” (Informant 2, interview)

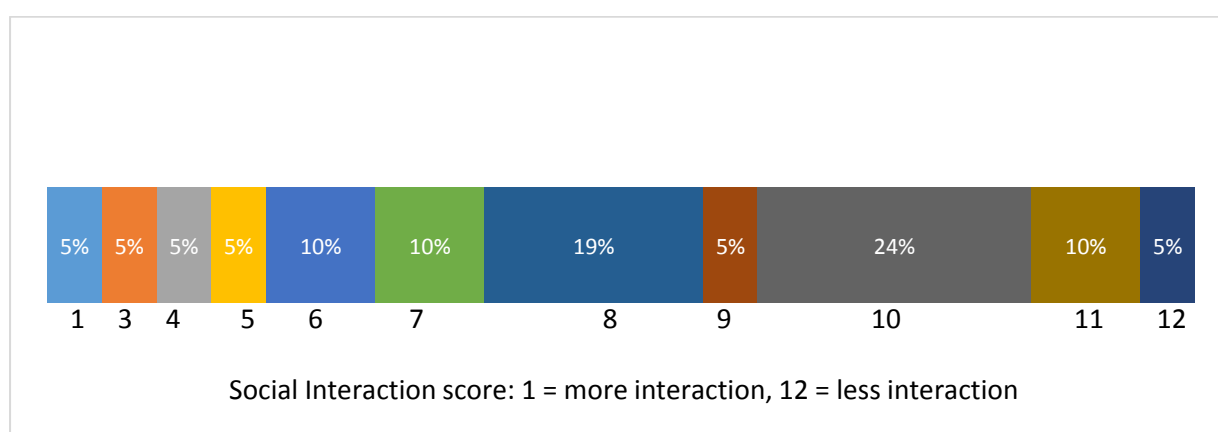
However, for others it can be specific circumstances which promote loneliness which require service input, for example communication difficulties. Even here, providers caution against the idea that loneliness can be essentially ‘solved’, as the isolation resulting from communication difficulties may remain even with befriending in place.

4.2.2 Social isolation

Social isolation may be associated with loneliness, but it can also exist independently. Scores on the social isolation measure (figure 8, illustrating scores from 21 respondents) indicate that levels among service users are relatively higher than that of loneliness.

It is therefore relevant to identify social isolation, but not to assume that it will always be perceived as a problem of loneliness by older people themselves. However, tackling social isolation means that there is an opportunity to reduce any loneliness experienced as a consequence and to ensure that older people have access to better social support.

Figure 8: Percentage of respondents who scored each social interaction score – social interaction score is recorded by numbers under the bar (total of 21 respondents)



Providers often identified social isolation as linked not only to loneliness, but more broadly to low mood and poor mental health in general, as the following quote indicates:

“If you go round to see somebody and they haven’t seen anybody all week, they’re not going to get up in the morning and get dressed. They’re not going to sit there and eat. It just doesn’t happen, they become really, really low. No routine, they just can’t be bothered anymore, what’s the point?” (Provider 2, interview)

Social isolation was identified as a significant barrier to accessing services. There was also a particular emphasis on the problems of more rural settings:

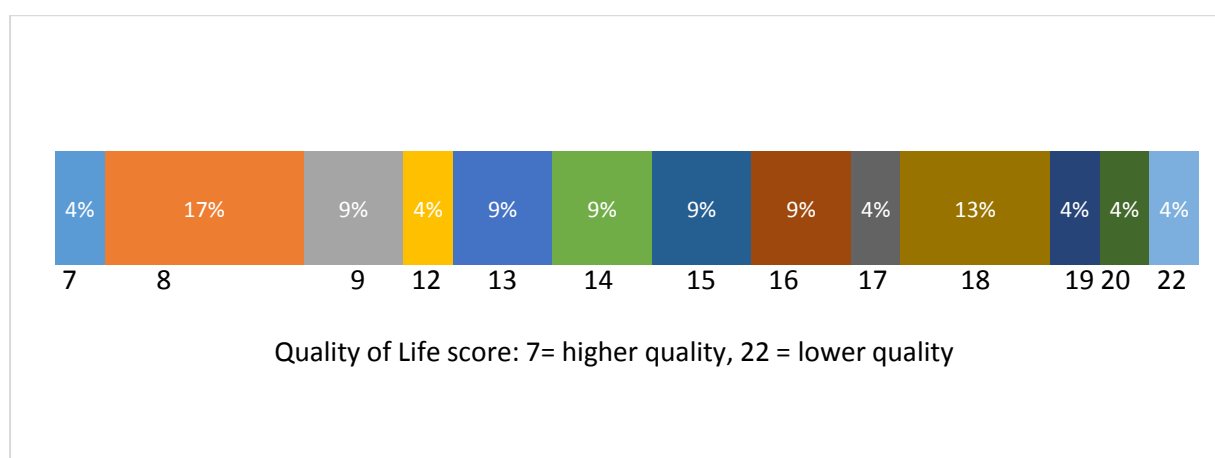
“[There are] lots of little villages, and obviously those people have got older and they can’t get out, they can’t drive anymore, so that’s made their situation ten times worse.” (Provider 3, interview)

Accordingly, transport was mentioned as a recurrent issue. Lack of transport has been linked to loneliness and isolation, particularly in rural areas (Drennan et al, 2008). For some clients, especially those with visual impairment, transport alone was insufficient as they also lacked confidence to travel unaccompanied. Visual impairment, along with a range of communication difficulties, was highlighted across providers as contributing significantly to social isolation.

4.2.3 Quality of life

The quality of life scale (figure 9, scores from 23 respondents) again indicates variability in service users' perceptions of their well-being. Quality of life is a multi-dimensional concept, as reflected in the questions used. The issue of finance is highly relevant and links to the ability to access services and to participate in social activities. Both transport and fuel poverty were flagged up as problematic by providers. In addition, certain disabilities could have considerable financial implications due to the need to purchase equipment or home adaptations. In these circumstances, providers saw themselves as able to offer if not actual funding then advice on how to use funds wisely. They may also be a source of information on whether grants or benefits may be available.

Figure 9: Percentage of respondents who scored each quality of life score – quality of life score is recorded by numbers under the bar (total of 23 respondents)



It is common for service users to experience a range of mental health problems, with depression and anxiety flagged up by providers, alongside the broader quality of life questions. The issue of satisfying social relationships was also highlighted. One informant commented that even when people have families they may not always have the opportunity to spend time with them in the way they would want.

“They have family, but family who work full-time and who have got children and very busy lives. So they might pop in once a week or once a fortnight, or the grandchildren might pop in, if they’ve got older grandchildren, might pop in and do some cleaning for them once a week, but they’re not coming in to spend quality time, they’re coming to do practical things.”
(Informant 1, interview)

Again, the impact of communication difficulties was highlighted. Sensory loss and resultant communication difficulties have been linked to impaired quality of life and well-being in older adults (Heine and Browning, 2009).

4.3 A picture of complex needs

The picture of needs emerging from the data is that they are complex, multi-faceted and interacting. Quite often it may be difficult to identify single issues which can easily be resolved, although when this does occur there is a capacity to make remarkable differences to people's lives.

Providers commented that they dealt with people who had been recently diagnosed with a condition and felt in a state of crisis, meaning their needs felt urgent. Often people might be experiencing multiple health problems. In other cases, service users who act as carers may find the pressures of the role prevent them from dealing with other needs.

“They’ve got the caring role, but they may also have problems that they’ve not dealt with that are nothing to do with their caring role as well, but then they’ve got the caring side of it as well they’re having to deal with.” (Provider 3, interview)

In many instances, therefore, any supportive intervention has to be seen in the context of small changes, or even simply maintenance, being a positive outcome (see section 3.3.2).

4.4 Meeting needs

Given the complexity of needs with which service users present, meeting these needs is not always straightforward. Befriending may not be the solution for everyone, but there was a clear consensus that it could be immensely valuable. The following quote from an informant demonstrates arguably the essential strength of befriending provision:

“They’re in the same four walls all day, every day, and they can’t, if they haven’t got the mobility to get out, they haven’t got the transport to get out, then they’re stuck there and all they really want is for someone to have a chat with them.” (Informant 1, interview)

This view is reinforced by one of the providers when they talk about the experience of acting as a befriender:

“I think it gives the client a purpose. If that is the only person that’s going in that week, they really look forward to that. They’re getting up in the morning, they’re getting ready, they’re focused on that person coming. I’ve got clients that write down everything that happens in the week, for when that person visits, so they can actually go through their week and say, “Well, this happened on Monday, and did you watch this programme?” but they will write it down. It makes a massive difference to their wellbeing. I can go and visit a client and when you get there, you know they’ve not seen anyone. You can tell from their voice they’ve not spoken. Their voice is croaky or it’s gone. By the time I’ve left, completely different person sitting in front of me.” (Provider 2, interview)

Befriending could also be seen as a way of compensating for changes in other services and patterns of activity which now have a less social component:

“But meals on wheels is delivered in freezers and people are given a microwave, and they warm it up themselves and they don’t see a human being.” (Provider 1, interview)

In terms of befriending provision, there can be very different responses to how it is delivered; this is very much not a case of one size fits all. Telephone befriending was seen as effective in many instances.

“I do telephone befriending as well, part of my role, and the clients that I ring, I get on fantastically well with, they love me ringing every week, we have a really good relationship.” (Provider 2, interview)

This reflects the findings of the Silver Line evaluation (Moore and Preston 2015), which found that telephone befriending could be an effective way of making contact with very isolated older people experiencing multiple and complex needs (see Appendix 2)

However, face-to-face befriending was held in particular regard. One informant compared it to telephone befriending in the following way:

“Well, because a lot of people can’t hear on the phone and it’s that personal interaction. Speaking to someone on the phone is not the same as looking at someone’s facial expressions and body language. It’s not the same as someone popping in, making a cup of tea, and sitting and having a proper chat with you. For elderly people who are on their own a lot of the time, a phone call doesn’t mean the same as someone actually coming into their home to visit them. It’s very different.” (Informant 1, interview)

When a provider was only in a position to offer telephone befriending, it could be problematic.

“We’re not receiving referrals for telephone befriending. We get referrals, when we say we can only offer telephone befriending, “It’s not what I want, I want face-to-face.”(Provider 3, interview)

Several providers expressed concerns that face-to-face befriending was not more universally available across Essex. It was recognised as resource-intensive, but highly valuable. One provider welcomed the fact that the Befriending Programme enabled them to do home visits in a way that other projects they ran did not, thus filling a gap in provision. Providers in general commented that while there were increasing numbers of older people who were being enabled to use digital communication such as Skype, these were still in the minority. Thus the capacity to use digital communication methods for befriending provision was limited, although facilitating the capacity to use technology could be an important aspect of provision.

Befriending can also be seen to have a value above and beyond the supportive one to one relationship at its heart. It also becomes a mechanism to identify other needs and for problems which have not previously been identified to become visible. Clients did not always know where to find help or what was available. In this respect, providers – along with others such as community agents - played an important role in signposting services. One key informant spoke of someone they had encountered who was in extreme need and completely incapacitated, but had ‘dropped off the radar’ of services such as their GP, and were unable to access help as they had no telephone.

One provider spoke of the way in which befriending could support people in vulnerable situations:

“There’s an element of safeguarding in there. You’re going into someone’s home in the community and as a befriender you might spot something that the GP in a surgery doesn’t. You know, the fact that they’re not putting the heating on at all, because they can’t afford to refill the oil tank. That there’s massive piles of post from the people trying to squeeze money out of...you know, the charities trying to squeeze money out of people. To look out for those sort of things, financial abuse, fuel poverty, elder abuse. If there’s a befriender in place they might spot some unusual family dynamics if there are other family visiting. So, I think it’s a really important role.” (Provider 1, interview)

This was echoed by a different provider:

“Saying it’s a befriending service I think detracts from what actually that service does, because the volunteers also keep an eye on them, so they’re our eyes and ears, so they’ll tell us if so-and-so is deteriorating and we get other agencies involved, or we’ll ring them ourselves.” (Provider 2, interview)

Providers were also aware of the limits to befriending, though. It was perceived as not being right for everyone. There was also a danger that people could be wrongly referred. Sometimes this might be because anxious relatives or professionals were actually simply looking for a sitting service. At other times, it was simply concern for someone who seemed in a difficult situation, and yet in practice the person in question simply did not want a befriender.

“We get referred by family members and when we ring them, perfect 96-year-old round the corner, “I don’t want nobody, what do you want to come round and speak to me for?” but the granddaughter was worried about him, so I said, “Look, I can keep an eye if ever you can’t get hold of him, give me a call, I’ll go round there, but he doesn’t want a befriender. He don’t, he’s independent, you might think he wants one, but he doesn’t.” (Provider 4, interview)

It should also be borne in mind that the umbrella term of ‘befriending’ in this context need not always refer to a sustained one to one relationship. It can also encompass a wider range of social activities, such as accompanying clients to events, social outings or clubs. It can also happen less formally through the offering of friendly companionship while assisting with transport, for example. At workshop 2, there was discussion of the importance of how befriending was branded. In some instances, befriending may not always feel like a concept that people are comfortable or familiar with. Providers stressed the necessity of customising how support was described so that it felt appropriate to different individuals.

One implication of this is that it is fruitful to understand the concept of befriending in the widest possible sense. There are a range of activities and contacts which can benefit people immensely, and by no means all are achieved through formal service provision. This project illustrates that it can be more helpful to focus on the outcomes for service users, namely an impact on loneliness, social isolation or quality of life, than on the exact route by which they are delivered.

Another important way in which befriending provision was found to meet need was in blurring the lines between clients and volunteers. Several providers emphasised the rewards that volunteers gained from offering befriending and cited instances of clients who subsequently became volunteers. Therefore befriending provision has more beneficiaries than simply the initial clients.

“So, when you’ve been supported by other people, to then go on to feel well enough to volunteer and support other people, it’s movement.” (Provider 1, interview)

Some of the most effective befriending came from peers who were able to identify a common link with the person referred. A shared interest or experience could be invaluable. This also reinforced the benefit which volunteers could gain from the process. Retaining volunteers can depend on the degree to which they are able to find satisfaction in their role and whether they have a good sense of what they are taking on.

4.5 Conclusions

- Loneliness, social isolation and reduced quality of life were all identified as significant sources of difficulty for service users
- Service users' needs are complex, interrelated and multi-faceted
- Befriending provision can be very valuable in itself, but it also serves to identify other needs among service users which may otherwise remain hidden
- Wider needs include lack of financial resources, transport problems, mental health difficulties including dementia, and lack of knowledge of service provision
- Befriending provision can be delivered effectively by different means, but there is some evidence that people who use services most value face-to-face
- Befriending provision is not suitable for everyone and sometimes clients can be wrongly referred
- Befriending is a valuable source of peer-to-peer support and can be rewarding for volunteers, although it is important that they gain satisfaction from their role and understand what they are taking on

5: WORKING TOGETHER TO TACKLE LONELINESS AND SOCIAL ISOLATION

The evaluation framework project was set in the context of a model for delivering befriending services which consists of a number of third sector providers working in tandem. Co-producing the evaluation framework brought these providers together and required collaboration. As such, it reflected attitudes to collaborative working both on the production of the framework itself and in the joint provision of the befriending services.

5.1 A case study in collaborative working: rewards and tensions

It is well recognised that loneliness is a complex and varied phenomenon (Moore and Preston, 2015; Victor et al, 2005). For example, different people feel that they lack different types of relationship: some want a close companion to confide in, while others want friends to socialise with. The reason people become lonely also differs: for some it is a lifelong feeling, while for others, the challenges of old age precipitate loneliness. For these reasons and more, one solution to loneliness is unlikely to suit everyone (Gierveld and Fokkema, 2015). The solutions themselves are also variable. Befriending by telephone is a different intervention from face-to-face befriending. The nature of the relationship formed in befriending is also variable. In some cases, the befriender is primarily a source of useful information and practical help, and in others, a source of empathy and emotional support.

Under these circumstances, a Befriending Programme which brings together a network of providers offering diverse services has the potential to produce a flexible set of options for older people and collaborative advantage for the providers, as they pool their expertise, knowledge and resources. However, as research into collaborations under various circumstances shows, the advantages of collaboration are not guaranteed (Vangen, 2016). Collaborative endeavours often face significant tensions as partners seek to simultaneously protect and integrate their resources in pursuit of joint collaborative goals (Vangen, 2016).

The research conducted for this project demonstrated that in this case too, there was a mix of rewards and tensions arising from the collaboration. These fell into four main categories, as outlined in the following sections.

5.1.1 Joint evaluation as a catalyst for wider collaboration

Providers reported that participating in the evaluation framework project was in itself conducive to collaboration, both in the evaluation framework project and in the wider Befriending Programme. This was because the evaluation framework project was an opportunity to meet other participants in person, find out more about what they were doing and build working relationships:

“I think everyone can see they’re doing different things and it’s good, because before we got involved with this...obviously with the extra funding, we’re now having meetings with all the other providers, so then you get to know more about what they’re actually doing.” (Provider 3, interview)

As a result, some providers felt able to refer clients with particular needs to other providers. For example to organisations providing support for carers or help with using technology such as computer tablets.

At the end of workshop 1, several providers also discussed getting together to advertise for volunteers across Essex, with the idea that sharing enquiries about volunteering across locations would be beneficial to all the providers.

These incidents illustrate the potential for events which bring providers together to act as a catalyst for subsequent collaboration.

5.1.2 Identifying gaps in provision through collaboration

The choice of which providers were involved in the Befriending Programme reflected both their geographic location and the kind of services they offered; the objective being to have a mix of befriending services across the county. However, in the course of the working together, it was clear to providers that there were certain gaps in befriending provision. For example, someone wanting face-to-face befriending might live in an area of Essex where that service is not provided, or someone needing support for hearing impairment might find it hard to access appropriate services where they live.

“I think collectively we’ve got all the services here that we all need, but they don’t cover all the areas in Essex. That’s the biggest problem we’ve found.” (Provider 5, workshop 1)

On occasion, providers wanted to refer people who came to them to other services but the providers who offered those services didn’t necessarily cover the area in question. Striking the right balance between offering Essex-wide provision of some services and localised provision of others is clearly a challenge in this model of befriending provision.

The collaboration also highlighted certain underlying factors that were hampering the ability of older people to overcome their loneliness and social isolation. In particular, inadequate transport was a feature for many and prevented people accessing what services there were, joining community groups or participating in community events. Some providers were addressing these problems directly by organising transport themselves. This, however, raises the issue of the extent to which the need for transport can be met by the third sector.

Another factor which various providers mentioned was dementia and its role in exacerbating loneliness and social isolation. For this reason, it may be advisable to record more systematically which clients have dementia so that specialist support can be accessed.

5.1.3 The role of referrers

The project highlighted the role of community agents and social care in helping link diverse service provision across a network of providers. While not all providers were connected with the community agents, those who were felt they were important conduits in the Befriending Programme and more widely:

“I think they’re fantastic. I know all the agents that work in my area.” (Provider 2, interview)

"I love the community agents. I've got really good relationships with them, because it's a two-way thing. So, if a befriender has spotted something, we can put a referral into community agents, if it's not with them already, and vice versa. So, it's that whole net round people, stopping them falling through the gaps and ending up in hospital." (Provider 1 interview)

The community agents also spoke about how they work with other agencies in the collaborative mix to help identify vulnerable people.

"I work alongside the WIs [Women's Institutes]...we're all part of core group meetings, we all have our own set of meetings. Neighbourhood Watch, they're a massive resource for us because obviously they know where the vulnerable people are in their streets." (Informant 1, interview)

Another role the community agents say they are fulfilling is to identify providers who may be having difficulties acting on referrals:

"If we're getting a referral partner that consistently isn't picking things up or isn't acting, then that is fed back and then they [community agents' managers] will take that up at a higher level, at whoever the referral has been set up with at a higher level, and try and work out what's going on, what the problem is really. It might be that they're overwhelmed and they haven't got capacity to take more people on." (Informant 1, interview)

While some providers felt positive about their relationship with social care due to the large numbers of referrals they got from them, others drew attention to the incidence of misguided referrals from social care and the inadequacy of information about clients in certain cases. This suggests the need for better ongoing communication between those providing befriending services and those referring to them, to ensure that the referrers understand what services are being provided by which organisations.

5.1.4 Tensions over referrals and volunteers

However, the project also suggested there were underlying tensions between providers over referrals. Various providers voiced disappointment about the lack of cross referrals:

"I haven't had any referrals from any of them or anything like that, but I suppose a new team takes time, doesn't it?" (Provider 4, interview)

The project provides a snapshot of the rate at which new clients are joining befriending services. This was quite low at the time and it may be that the paucity in client numbers overall was exacerbating a sense of needing to compete for the few clients there were. But equally, the low level of new clients may also have been a symptom of a reluctance among providers to share referrals with one another.

"Collaborating with other people, I'm quite happy to - about sharing good practice, sharing good ideas, making things work well for people - but you do notice when you start to do that, people are very protective of their own thing, their own way of doing things." (Provider 1, interview)

One way of addressing any reluctance among providers to refer on to other providers may be to treat these referrals as outcomes. This might incentivise cross referrals. The evaluation framework provides for systematic recording of referrals but does not formally treat cross-referrals as outcomes.

There was also evidence of similar tensions around volunteers:

“I think some organisations want to hang onto their own volunteers. I think you need to be working together more, rather than working separately. Somebody may have a volunteer that’s not suitable for them or at that time, then somebody else could use that volunteer.”
(Provider 2, interview)

As with the protective attitude to referrals, any reluctance to share volunteers should be seen in the light of the difficulty many providers face in recruiting them:

“I think it is a lot of these organisations are volunteer-based and it’s getting the volunteers, and no one can get volunteers.” (Informant 1, interview).

5.1.5 Funding regimes affect attitudes to collaboration

The existence of tensions over sharing clients and volunteers are perhaps unsurprising given a background in which providers frequently have to compete directly with one another to secure funding:

“There are funding wars going on all the time. That’s natural. If there’s a pot of money up for grabs, everyone wants it, everyone’s going to put bids in for it.” (Informant 1, interview)

“There’s a little bit of, ‘Don’t step on my patch or my funding’, which is entirely understandable.” (Provider 1, interview)

This situation might be alleviated by ECC tendering in such a way as to positively encourage consortium bids. Various providers also spoke about their positive experience in partnership working in other situations and suggested that this was the way forward for smaller charities in particular:

“Things have got to change somewhere, because small charities will go to the wall without working with each other I think.” (Provider 1, workshop 1)

5.2 Conclusions

- A Befriending Programme comprising a network of diverse providers can produce a flexible set of options for older people and bring collaborative advantage for the providers
- This depends in part on a well-functioning referral system, where there is clear understanding of which organisations provide which services and a willingness to refer clients on where appropriate
- It also requires striking the right balance between Essex-wide provision of some services and localised provision of others
- Joint evaluation can foster collaboration over the evaluation itself and act as a catalyst for wider collaborations
- Collaborating over the evaluation and in the befriending project helped identify gaps in befriending service provision and in underlying services such as transport

- It also highlighted the incidence of dementia among many people accessing services and the potential benefits of recording this more systematically
- Collaborations can produce tensions as partners seek to simultaneously protect and integrate their resources in pursuit of joint collaborative goals
- In the Befriending Programme, this manifests in the presence of tensions over attracting and retaining clients and volunteers
- One way of counteracting any reluctance for providers to refer people on to other providers may be to count cross referrals as an outcome
- A competitive environment for funding can hamper collaborative attitudes to service delivery. Tenders which encourage consortium bids may alleviate this situation

6: CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

This project demonstrates that a co-produced evaluation framework is both achievable and valuable. Despite some reluctance among providers to use common measures, a shared approach was developed which proved effective. Although there were some differences in approach, providers worked productively together to shape the framework.

The framework itself successfully identified a range of needs among service users. It was also sufficiently sensitive to discriminate between different levels of severity of need.

Collaboration was promoted through participation in two face-to-face workshops, and this had benefits beyond the design of the evaluation template itself. Providers gained a better understanding of each other's services, which is essential to facilitate cross-referrals and to reduce competitiveness or undue protectiveness.

While this project was not an evaluation of befriending provision itself, findings do suggest that befriending is a valued service which can influence levels of loneliness, social isolation and quality of life. It also has the capacity to identify needs which may otherwise remain hidden and to improve access to services. Importantly, befriending provision can act as a catalyst for community mobilisation and does not necessarily entail formal service provision.

6.2 Recommendations

- The evaluation framework can be used effectively across a range of providers offering different services which address complex needs
- Service design needs to strike a balance between location and the nature of provision
- Collaboration between providers is to be valued and can be promoted through events such as face-to-face workshops
- Funding mechanisms can also be used to prompt collaboration rather than competition
- The voices of people in Essex should be heard in service design and evaluation in order to ensure that they have choice and control
- Befriending provision is a valuable alternative to more formal services, but care needs to be taken in how it is branded, as the term may not be meaningful or attractive to everyone
- Befriending can be most effective if it is understood in its widest sense, as a range of activities and contacts which have the potential to improve loneliness, social isolation and quality of life
- Third sector organisations are capable, flexible and responsive providers of befriending services
- Evaluations of provision should also capture the impact of participation on volunteers

References

Andrews, G.J., Gavin, N., Begley, S. and Brodie, D., 2003. Assisting friendships, combating loneliness: users' views on a 'befriending' scheme. *Ageing & Society*, 23(3), pp.349-362.

Attard, A. and Coulson, N. S., 2012. A thematic analysis of patient communication in Parkinson's disease online support group discussion forums. *Computers in Human Behavior*, 28(2), pp.500-506.

Bouwman, T.E., Aartsen, M.J., van Tilburg, T.G. and Stevens, N.L., 2016. Does stimulating various coping strategies alleviate loneliness? Results from an online friendship enrichment program. *Journal of Social and Personal Relationships*.

Butler, S.S., 2006. Evaluating the Senior Companion Program: a mixed-method approach, *Journal of Gerontological Social Work*, 47, (1-2), pp.45–70.

Caplan, S. E., 2002. Problematic Internet use and psychosocial well-being: Development of a theory-based cognitive-behavioral measurement instrument. *Computers in Human Behaviors*, 18, pp.553–575.

Care Act, 2014. Available at:

http://www.legislation.gov.uk/ukpga/2014/23/pdfs/ukpga_20140023_en.pdf

Cattan, M., Kime, N. and Bagnall, A., 2011. The use of telephone befriending in low level support for social isolated older people – an evaluation. *Health and Social Care in the Community*, 19,(2), pp.198-206.

Cattan, M., White, M., Bond, J. and Learmouth A., 2005. Preventing social isolation and loneliness among older people: a systematic review of health promotion interventions. *Ageing and Society*, 25, pp.41-67.

Charlesworth, G., Shepstone, L., Wilson, E., Reynolds, S., Mugford, M., Price, D., Harvey, I. and Poland, F., 2008. Befriending carers of people with dementia: randomised controlled trial. *BMJ*, 336, (7656), pp.1295–1297.

Choi, M., Kong, S. and Jung, D., 2012. Computer and internet interventions for loneliness and depression in older adults: A meta-analysis. *Healthcare Informatics Research*, 18, pp.191.

Cohen-Mansfield, J. and Perach, R., 2015. Interventions for alleviating loneliness among older persons: a critical review. *American Journal of Health Promotion*, 29, pp109–125.

Dean, J. and Goodlad, R., 1998. *Supporting community participation: the role and impact of befriending*. Joseph Rowntree Foundation, York.

Drennan, J., Treacy, M., Butler, M., Byrne, A., Fealy, G., Frazer, K. and Irving, K., 2008. The experience of social and emotional loneliness among older people in Ireland. *Ageing & Society*, 28(8), pp.1113-1132.

Essex Country Council, 2013. *Joint Strategic Needs Assessment – Countywide Report*. Available at: <https://www.essexinsight.org.uk/get/ShowResourceFile.aspx?ResourceID=299>

Essex County Council, 2016. *Health and Wellbeing Report*, Available at: <http://www.essexinsight.org.uk/Resource.aspx?ResourceID=1335>

Findlay, R.A., 2003. Interventions to reduce social isolation amongst older people: where is the evidence? *Ageing & Society*, 23, pp.647–658.

Garattini, C. J., Wherton and Prendergast, D., 2012. 'Linking the lonely: an exploration of a communication technology designed to support social interaction among older adults', *Universal Access in the Information Society*, 11(2), pp.211–22.

Gierveld, J.D. and Fokkema, T., 2015. Strategies to prevent loneliness. In Sha'ked, A. and Rokach, A. (eds), *Addressing Loneliness: Coping, Prevention and Clinical Interventions* (Vol. 1). Psychology Press, New York, pp.218-230.

Gierveld, J. D., and Van Tilburg T.G., 2006. A six-item scale for overall, emotional and social loneliness: confirmative tests on new survey data. *Research on Aging*, 28,(5), pp.82–598.

Green, J., Jones, A. and Roberts, H., 2014. More than A to B: the role of free bus travel for the mobility and wellbeing of older citizens in London. *Ageing & Society*, 34(03), pp.472-494.

Hawkley, L. C., Hughes, M. E., Waite, L. J., Masi, C. M., Thisted, R. A. and Cacioppo, J. T., 2008. From social structural factors to perceptions of relationship quality and loneliness: The Chicago health, aging, and social relations study. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 63(6), pp.S375-S384.

Heine, C. and Browning, C. J., 2009. Communication and psychosocial consequences of sensory loss in older adults: overview and rehabilitation directions. *Disability & Rehabilitation*, 24(15), pp.763-773.

Hodge, S. and Eccles, F., 2013. Loneliness, social isolation and sight loss: a literature review conducted for *Thomas Pocklington Trust*.

Holt-Lunstad, J., Smith, T.B., Baker, M., Harris, T., Stephenson, D., 2015. Loneliness and Social Isolation as Risk Factors for Mortality: A Meta-Analytic Review. *Perspectives on Psychological Science* 10, 227–237.

Lester, H., Mead, N., Graham, C.C., Gask, L. and Reilly, S., 2012. An exploration of the value and mechanisms of befriending for older adults in England. *Ageing & Society*, 32, pp.307–328.

Lindley, S., 2012. 'Shades of lightweight supporting cross-generational communication through home messaging', *Universal Access in the Information Society*, 11(1), pp.31–43.

Martina, C.M.S. and Stevens, N.L., 2006. Breaking the cycle of loneliness? Psychological effects of a friendship enrichment program for older women. *Ageing & Mental Health*, 10(5), pp.467-475.

Masi, C.M., Chen, H.Y., Hawkley, L.C. and Cacioppo, J.T., 2011. A meta-analysis of interventions to reduce loneliness. *Personality and Social Psychology Review*, 15, pp.219–266.

McAuley, E., Blissmer, B., Marquez, D.X. et al, 2000. Social relations, physical activity, and wellbeing in older adults. *Preventative Medicine*, 31, pp.608–617.

McNeil, J.K., 1995. Effects of nonprofessional home visit programs for subclinically unhappy and unhealthy older adults. *Journal of Applied Gerontology*, 14,(3), pp.333-342.

- Mead, N., Lester, H., Chew-Graham, C., Gask, L. and Bower, P., 2010. Effects of befriending on depressive symptoms and distress: systematic review and meta-analysis. *BJP*, 196, pp.96–101.
- Miles, M.B. and Huberman, A.M., 1994. *Qualitative data analysis: An expanded sourcebook*. Sage, London.
- Monk, A.F. and Reed, D.J., 2007. *Telephone conferences for fun: experimentation in people's homes*. Chennai, India: HOIT, Springer.
- Moore, S. and Preston, C., 2015. *The Silver Line: Tackling Loneliness in Older People*. Cambridge: Anglia Ruskin University.
- Munn-Giddings, C. and Winter, R. 2013. *A handbook for Action Research in Health and Social Care*. Routledge.
- Nef, T., Ganea, R.L., Müri, R.M. and Mosimann, U.P., 2013. Social networking sites and older users – a systematic review. *International Psychogeriatrics*, 25, pp.1041–1053.
- Nimrod, G., 2010. Seniors' Online Communities: A quantitative content analysis. *The Gerontologist*, 50, pp.382–392.
- Nyman, S.R., Dibb, B., Victor, C.R. and Gosney, M.A., 2012. Emotional well-being and adjustment to vision loss in later life: a meta-synthesis of qualitative studies. *Disability and Rehabilitation*, 34, pp.971–981.
- Pronk, M., Deeg, D.J.H. and Kramer, S.E., 2013. Hearing status in older persons: A significant determinant of depression and loneliness? Results from the longitudinal aging study Amsterdam. *American Journal of Audiology*, 22, pp.316.
- Routasalo, P.E. and Pitkala, K.H., 2003. Loneliness among older people. *Reviews in Clinical Gerontology*, 13, pp.303–311.
- Routasalo, P.E., Tilvis, R.S., Kautiainen H. and Pitkala, K.H., 2009. Effects of psychosocial group rehabilitation on social functioning, loneliness and well-being of lonely, older people: randomized controlled trial. *Journal of Advanced Nursing*, 65, pp.297–305.
- Seepersad, S., 2015. Helping the “poor get richer” – successful internet loneliness intervention programs. In Sha'ked, A. and Rokach, A.(eds), *Addressing Loneliness: Coping, Prevention and Clinical Interventions* (Vol. 1). Psychology Press, New York, pp.231–240.
- Senra, H., Barbosa, F., Ferreira, P., Vieira, C.R., Perrin, P.B., Rogers, H., Rivera, D. and Leal, I., 2015. *Psychologic Adjustment to Irreversible Vision Loss in Adults*. *Ophthalmology*, 122, pp.851–861.
- Shergold, I., Parkhurst, G. and Musselwhite, C., 2012. Rural car dependence: an emerging barrier to community activity for older people. *Transportation Planning and Technology*, 35(1), pp.69–85.
- Stanley, M., Moyle, W., Ballantyne, A., Corlis, M., Oxlade, D., Stoll, A. and Young, B., 2010. 'Nowadays you don't even see your neighbours': loneliness in the everyday lives of older Australians. *Health and Social Care in the Community*, 18(4), pp.407–414.
- Stevens, N. L., 2001. Combating loneliness: A friendship enrichment programme for older women. *Ageing & Society*, 21, pp.183–202.

Tse, M., 2010. Therapeutic effects of an indoor gardening programme for older people living in nursing homes. *Journal of Clinical Nursing*, 19(7-8), pp.949-958.

Vangen, S., 2016 Developing Practice-Oriented Theory on Collaboration: A Paradox Lens. *Public Administration Review*.

Victor, C.R., Scambler, S.J., Bowling, A., Bond, J., 2005. The prevalence of, and risk factors for, loneliness in later life: a survey of older people in Great Britain. *Ageing & Society* 25, 357–375.

Wikstrom, B.M., 2002. Social interaction associated with visual art discussions: a controlled intervention study. *Aging & Mental Health*, 6, pp.82–87.

Winningham, R.G. and Pike, N.L., 2007. A cognitive intervention to enhance institutionalized older adults' social support networks and decrease loneliness. *Ageing & Mental Health*, 11, pp.716–721.

Appendix 1: Template questionnaire

Questions marked with * are to be asked at baseline *and* follow up assessments

Questions marked with ** are to be asked at final assessment *only*

Questions without * are asked at baseline *only*

Answers to these questions should be entered onto a spreadsheet

Administrative and demographic data

1. *Client ID (organisation ID forms part of this):
 2. *Date of assessment: DD/MM/YYYY
 3. *Assessment number (1=baseline assessment):
 4. Gender: Male, Female, Other, Prefer not to say
 5. Date of birth: DD/MM/YYYY
 6. Area of residence:
 7. *Referral information
- 7a) note any services within your organisation you have referred the client to:
7b) note any other organisations you have referred the client to:
7c) note any community provision you have referred the client to:

*** Key contributory factors**

1. Do you have any long-standing illness, disability or infirmity? (By long-standing I mean anything that has troubled you over a period of time of that is likely to affect you over a period of time)

RESPONSE

Yes

No

*** Outcome 1: Loneliness**

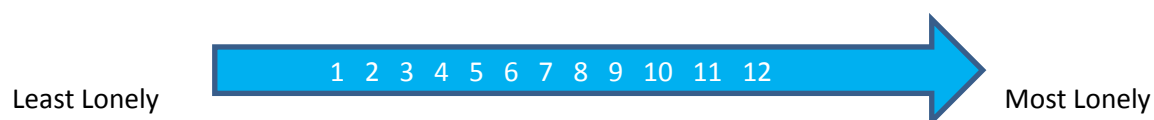
1. I am content with my friendships and relationships
2. I have enough people I feel comfortable asking for help at any time
3. My relationships are as satisfying as I would want them to be

RESPONSE

SCORE

STRONGLY DISAGREE	4
DISAGREE	3
NEUTRAL	2
AGREE	1
STRONGLY AGREE	0

Add scores for total



*** Outcome 2: Social Interactions**

On average.....

1. How often do you meet with family/friends or neighbours?
2. How often do you communicate with family/friends on the telephone/internet/using another communication device?
3. How often do you go out shopping/visit the library/go on another regular outing?
4. During a week, how many different people do you usually communicate with?

Q. 1-3

RESPONSE	SCORE
ONCE A MONTH OR LESS	4
ONCE OR TWICE A FORTNIGHT	3
ONCE A WEEK	2
EVERY FEW DAYS	1
EVERY DAY OR MORE	0

Q 4

Response	0	1-2	2-3	3-4	5+
Score	4	3	2	1	0

Add scores for total



*** Outcome 3: Quality of Life**

1. I am happy with my financial wellbeing
2. My physical wellbeing is good
3. I have positive relationships with others
4. I feel part of my local community
5. I have a hobby or pastime I enjoy doing regularly
6. Overall I rate my level of happiness as high

RESPONSE	SCORE
STRONGLY DISAGREE	4
DISAGREE	3
NEUTRAL	2
AGREE	1
STRONGLY AGREE	0

Add scores for total



**** Outcome 4: Client view on what has been useful**

1. What has been the most helpful part of the process for you? (max 50 words)
2. Is there anything in particular that's better for you now? (max 50 words)

**** Outcome 5: Provider comments on client experience**

1. Identify 3 key factors you feel capture the client's experience of the service (max 50 words)

Appendix 2: Literature review

What works in tackling loneliness and social isolation?

Various academic studies have sought to understand what works in combatting loneliness and social isolation among older people by considering the results of a number of independent evaluations together. These meta-analyses and reviews come to mixed conclusions about the most effective ways of tackling these problems. One early systematic review reported that educational and social activity group interventions that target specific groups can alleviate social isolation and loneliness among older people but that the effectiveness of home visiting and befriending schemes remained unclear (Cattan et al, 2005). A more recent meta-analysis of interventions addressing loneliness in groups not confined to older people (Masi et al, 2011) found that among the randomised-control studies of interventions it included, those addressing ‘maladaptive social cognition’ had a greater impact than interventions addressing social support, social skills and opportunities for social contact. (Maladaptive social cognition, in this context, refers to ways of thinking that create or exacerbate feelings of loneliness.) However, many of the successful interventions of this type were not targeted at older people. A second recent review found that it is possible to reduce older people’s loneliness using educational interventions focused on maintaining and enhancing social networks but it did not comment on befriending interventions since none were included in its round-up (Cohen-Mansfield and Perach, 2015).

One thing these and other reviews agree on is that it is hard for interventions to achieve *substantial* reductions in loneliness and the interventions are often effective only under particular circumstances (Gierveld and Fokkema, 2015). This has been blamed, in part, on the number of external factors that can exacerbate loneliness during the course of any particular intervention, for example, the death of a partner or close friend or the onset of ill-health. There are also more fundamental structural factors which contribute to loneliness and social isolation, such as poverty and living in a rural area, but addressing these issues is beyond the remit of the more direct interventions considered here.

Direct interventions can give support in:

- maintaining existing relationships – eg, technology and transport-oriented schemes
- building new relationships – eg, schemes such as befriending, social activities and use of communication technologies
- changing ways of thinking – eg, educational or therapeutic interventions

Maintaining existing relationships

There are various ways that people can be helped to maintain their existing connections, including ensuring they have adequate transport and technology. Access to transport has been shown to be important both for older people maintaining friendship networks in London (Green et al 2014) and participating in community activities in rural areas (Shergold et al, 2012). On the technology front, the growth in internet use among older people raises the question of whether the online

environment can provide relief from loneliness. The relationship between the internet and loneliness has been the subject of much debate and previous claims that the internet makes people lonely (Seepersad, 2015) have been modified by the finding that lonelier people tend to use the internet in solitary or problematic ways (Caplan 2002, Seepersad 2015) which increase their level of loneliness. Overall, there is some agreement that *the way* people use both the internet and social media is key to whether it amplifies or reduces feelings of loneliness (Seepersad, 2015). On the issue of the ability for internet interventions to help older adults maintain contacts, one meta-analysis of several studies concludes that interventions which improve older people's computer and internet skills increase opportunities for interaction with existing friends and family, and thereby reduce loneliness (Choi et al, 2012). A review of studies looking at older people's use of social networking sites, in particular, found that their main benefit was on intergenerational communication, between older people and younger family members (Nef et al, 2013). A field trial of a communication device linking older people with their family networks similarly found it enabled grandparents to engage with teenage grandchildren in novel and playful ways (Lindley, 2012).

Targeted support at times when people face particular difficulties maintaining their contacts may also be useful. This could include support during the onset of ill-health or disabilities including sight and hearing loss since these experiences are known to put people at increased risk of loneliness (Hodge and Eccles, 2013; Nyman et al, 2012; Senra et al, 2015; Pronk et al, 2013).

Building new relationships

Befriending

Befriending consists of an affirming and emotion focused relationship which is set up and overseen by an agency (Mead et al, 2010). It is also characterised as non-judgemental, mutual and purposeful (Dean and Goodlad, 1998). Although companionship is central, befriending may also include accompanying people on activities or helping with chores (Findlay, 2003; Mead et al 2010; Cattani et al, 2011). It is recognised that befriending can help people in ways that go beyond the immediate scheme. For example, one study interviewing people who were using various types of befriending schemes found they gained emotional support and help connecting back into the community (Lester et al, 2012). Befriending can be carried out face-to-face, by telephone, in a one-to-one situation or in a group. This section initially reviews face-to-face befriending schemes and then turns to telephone schemes.

Relieving loneliness is not always the primary objective of face-to-face befriending schemes and their record achieving this objective is mixed. One example is a face-to-face befriending scheme for carers of people with dementia, which aimed primarily to improve psychological wellbeing and quality of life. A randomised control trial of the scheme failed to demonstrate any impact on these factors as well as on loneliness, which was among the secondary outcomes measured (Charlesworth et al, 2008). The authors did acknowledge that the research was limited by the low number of people who actually took up the befriending scheme. More positively, another small randomised study looked at the effect on physical health and happiness of a scheme that combined befriending with exercise (in the form of accompanied walking) (McNeill, 1995). It found that the conversation alone was associated with increased happiness (ibid). Positive results were also found in a face-to-face befriending service for people confined to the home, which aimed to enhance quality of life,

alleviate social isolation and maintain mental health (Andrews et al, 2003). This qualitative study, based on interviews with 13 service users, found they were very satisfied with the service and appreciated the reliability of the volunteer befrienders. They reported feeling less lonely and many valued the friendly reciprocity in their relationships with the befrienders, likening it to 'real' friendship (Andrews et al, 2003). A study into a Senior Companion Program measured levels of loneliness among its clients at one point in time and found them to be relatively low. Clients also said they valued the scheme for various reasons including that it provided companionship and reduced anxiety (Butler, 2006).

Telephone befriending has been subject to fewer independent evaluations but, as with face-to-face befriending, results are mixed. A recent study into the Silver Line, a national UK telephone helpline and befriending service, found that the service was demonstrably effective in reaching particularly lonely and socially isolated older people, who were also more likely to have a complex of mutually reinforcing problems such as poor physical and mental health, disabilities and low enjoyment of life (Moore and Preston, 2015). Users also reported that they were accessing the services to tackle various forms of loneliness and found them beneficial. However the study also measured the change in loneliness of people using the befriending service over six months but failed to show that it led to a meaningful reduction.

An evaluation of another phone based befriending service interviewed 40 older people using it, who said that it reduced their loneliness and anxiety as well as improved their confidence (Cattan et al, 2011). Another study found that telephone conference calls produce benefits such as enjoyment, reassurance and information-sharing (Monk and Reed, 2007).

Communication technologies

Older people's use of digital technology to maintain contact with people they already know was discussed above but it is also increasingly common for people to form *new* relationships online when they join groups that may be about support for health problems or based around shared interests or leisure activities. Studies show these can be helpful in forming friendships (Attard and Coulson, 2012), as well as having fun and improving wellbeing (Nimrod 2010), so help accessing them may be beneficial to older people. One study looked at a communication device that enabled users to listen or watch regular broadcasts and then join in a group chat via a phone handset. As a pilot study, it was more concerned with understanding patterns of use than outcomes but it found that people who scored high for social loneliness (Gierveld and Van Tilburg, 2006) became lead users and advocates of the device, whereas people who scored high for emotional loneliness were more ambivalent (Garattini et al, 2012).

Social activities

Another route to forming new friendships and tackling loneliness is through schemes that involve taking part in shared, face-to-face activities. Positive impacts have been found in social groups of this kind which involve gardening (Tse, 2010), physical activity (McAuley et al, 2000; Routsalo et al, 2009) and art discussions (Wikstrom, 2002), although beneficial effects do not always result.

Ways of thinking

Interventions which target ways of thinking include those addressing maladaptive social cognition (as discussed above), coping strategies, social skills training and cognitive enhancement. One study which falls into the cognitive enhancement category looked at a programme for older adults which aimed to maintain cognitive ability. It found that while the level of loneliness in the intervention group remained stable, it rose among those who didn't take part in the programme (Winningham and Pike, 2007). Another group of studies focused on a friendship enrichment programme which was developed offline (Stevens 2001; Martina and Stevens, 2006) and then online (Bouwman et al, 2016). The programme encouraged participants to become aware of their social needs and desires, to analyse their existing social network, to reflect on their expectations of friendships, to improve the quality of existing friendships, and to develop new friendships. Participants in the original version gained friendships but the study failed to demonstrate that it had a positive effect on their loneliness. The online version experienced a high drop out rate, as is common in other online self-guided interventions, but it showed some evidence of reduced loneliness among those who did stay the course (Bouwman et al, 2016). Although there are relatively few online interventions of this type addressing loneliness in older people (Seepersad, 2015), they may become more common as the number of older people using the internet rises.

Appendix 3: Outcomes measures (document circulated to participants)

Please read through this document before Workshop 1 and think about which measures (one from each section) would be most suitable to use in the evaluation

Issues we suggest considering when deciding which measure to use

1. How suitable is the measure for the population of people you will use it with?
2. How practical is it in terms of asking the questions in initial conversations with clients and afterwards?
3. How practical is it in terms of recording the answers and sharing that information?
4. Is the measure going to pick up on the kinds of change you expect your organisation to make?
5. Is it tested and used widely – so that people will respect results shown from using it?
6. Will it enable comparison with larger data sets?

The following pages cover common measures of loneliness, social interaction and quality of life. The pros and cons are debatable – these are not definitive lists but a presentation of some key points

Prepared by Anglia Ruskin University for Workshop 1, 28 April 2017

Loneliness

Option 1: DeJong Gierveld 6-item scale

Please indicate for each of the 6 statements, the extent to which they apply to your situation, the way you feel now. Please, circle the appropriate answer

1. I experience a general sense of emptiness
2. I miss having people around me
3. I often feel rejected
4. There are plenty of people I can rely on when I have problems
5. There are many people I can trust completely
6. There are enough people I feel close to

Answer choices are:

Yes

More or less

No

Pros – distinguishes between different types of loneliness; designed for older people; extensively used and tested; the mix of positive and negatively worded questions helps avoid biases in responding

Cons – longer than some alternatives; some reported difficulties with negative wording

Option 2: UCLA-3

These question are about how you feel about different aspects of your life. For each one, please say how often you feel that way

1. How often do you feel that you lack companionship?
2. How often do you feel left out?
3. How often do you feel isolated from others?

Answer choices are:

Hardly ever

Some of the time

Often

Pros – extensively used and tested; can be used as self-completion survey or over phone; comparable to national studies eg ELSA, also used by Age UK in various evaluations of loneliness/social isolation services

Cons – original longer version of scale developed with US students but UCLA-3 tested with older people; possible response bias due to all questions being negative; criticised for being one-dimensional, ie doesn't distinguish between emotional and social loneliness

Alternatives

Campaign to End Loneliness measure – not extensively used and tested

Single-item measures – various versions of single questions which directly ask about loneliness eg, 'Do you ever feel lonely?'. These are widely used but by may not pick up on loneliness in people who find the word stigmatising.

Various longer forms of UCLA such as the revised UCLA, Short-form UCLA (ULS-6)

Social interaction

Option 1: The social interaction questions from the Duke Social Support Index

1. Other than members of your family how many persons in your local area do you feel you can depend on or feel very close to?

Answer choices are:

None

1-2 people

More than 2 people

2. How many times during the past week did you spend time with someone who does not live with you, that is, you went to see them or they came to visit you or you went out together?

3. How many times did you talk to someone (friends, relatives or others) on the telephone in the past week (either they called you, or you called them)?

4. About how often did you go to meetings of clubs, religious meetings, or other groups that you belong to in the past week?

Answer choices are:

None

Once

Twice

Three times

Four times

Five times

Six times

Seven or more times

Pros – subsection of a validated scale

Cons – doesn't reflect new communication technologies; focuses on last week only; answer choices rather numerous

Option 2: Questions adapted from social interaction questions in ELSA

We would like to ask you some questions about things you do with other people

On average how often do you do each of these with a family member (not including people who live with), a neighbour or friend?

- a) Chat on the phone
- b) Make contact by letter or using a digital device eg texting, email, social media
- c) Have a meal
- d) Meet up in person (by chance or arrangement)

Answer choices for each option are:

Three or more times a week

Once or twice a week

Once or twice a month

Every few months

Once or twice a year

Less than once a year or never

Pros – do reflect various ways of getting in touch; time reference is not restricted to the last week

Cons – because they are adapted; they are not validated in this form

Alternatives

Ways of measuring social interaction/social isolation vary widely. The interventions in this project cannot be expected to impact on some types of questions commonly asked to measure social isolation, such whether the person lives alone and whether they have adequate access to means of transport. For this reason we have focused on measures of social interaction.

Quality of Life Measures

Option 1: EuroQoL 5 Dimension (EQ-5D-3L)

By placing a tick in one box in each group below, please indicate which statements best describe your own health state today.

1. Mobility

I have no problems in walking about
I have some problems in walking about
I am confined to bed

2. Self-Care

I have no problems with self-care
I have some problems washing or dressing myself
I am unable to wash or dress myself

3. Usual Activities (*e.g. work, study, housework, family or leisure activities*)

I have no problems with performing my usual activities
I have some problems with performing my usual activities
I am unable to perform my usual activities

4. Pain/Discomfort

I have no pain or discomfort
I have moderate pain or discomfort
I have extreme pain or discomfort

5. Anxiety/Depression

I am not anxious or depressed
I am moderately anxious or depressed
I am extremely anxious or depressed

6. To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked **100** and the worst state you can imagine is marked **0**. We would like you to indicate on this scale how good or bad your own health is today, in your opinion. Please do this by drawing a line from the box below to whichever point on the scale indicates how good or bad your health state is today.

Pros – widely used and recognised; facilitates cost utility analysis; questions relevant to these circumstances, correlates well with other less generic measures of QoL and can be used with them. Additional ‘bolt on’ questions for people with hearing and sight loss relating to how well they can see or hear (with aids/glasses) are available, although their impact depends on the severity of the condition (see Yaling et al 2015)

Cons – not developed for older people; the 3L version offers 3 answers in each case, an alternative 5L version offers 5 answers and is more easily adapted for cost utility analysis

Option 2 – OPQoL Brief

We would like to ask you about your quality of life

1. Thinking about both the good and bad things that make up your quality of life, how would you rate the quality of your life as a whole?

Answer choices are:

Very good
Good
Alright
Bad
Very bad

2. Please tick one box in each row.

Answer choices are:

Strongly agree
Agree
Neither agree nor disagree
Disagree
Strongly disagree

1 I enjoy my life overall

2 I look forward to things

3 I am healthy enough to get out and about

4 My family, friends or neighbours would help me if needed

5 I have social or leisure activities/hobbies that I enjoy doing

6 I try to stay involved with things

7 I am healthy enough to have my independence

8 I can please myself what I do

9 I feel safe where I live

10 I get pleasure from my home

11 I take life as it comes and make the best of things

12 I feel lucky compared to most people

Pros – developed with and for older people

Cons – longer than some alternatives; does not support cost utility analysis

Alternatives

WHO QOL OLD – 24 questions, 5 options each. Too long for this context

ASCOT (Adult Social Care Outcomes Toolkit) – 9 questions, 4 options each. Assumes people are in receipt of social care eg 'Thinking about the food and drink you *get*...' and 'Thinking about the way you are helped and treated...'

Warwick-Edinburgh Mental Wellbeing – 14 questions, 5 options each. Focuses on mental wellbeing, not specifically for older people

CASP-19 – 19 questions, 4 options each. Not developed for use by older people

Appendix 4: Supplementary information and case studies

Action for family carers

Action for Family Carers is the lead partner of a group of registered charities working together to support unpaid carers of all ages across Essex. Working together makes it easier for carers to access support when they need it and provides a single and consistent point of contact.

The Adult Carer team provide support delivered by phone, home visits, one-to-one support sessions and support groups. They are able to provide the following services:

- Information, advice and signposting
- Emotional support
- Peer-led support groups
- Access to Training
- Informal advocacy
- Support to complete benefits applications
- Information on how to get a break
- Support to access grant funding

Other services are also provided for young carers, respite care and Macmillan support for end of life care.

One of the support services provided is the telephone befriending service. All adult carers are eligible and can receive a telephone call from one of our telephone befriending volunteers on a regular basis for example, weekly, fortnightly or monthly. Currently the telephone befriending service covers Mid Essex, West Essex and Basildon and Brentwood.

Carers are often referred to the telephone befriending service once other work has been completed by an adult support worker, or it may be that the carer requires very little other support but would like to keep in contact with a regular call. A lot of carers referred to the telephone befriending service are in the older age group and may have health issues themselves. They may also be isolated as they are unable to leave the home very often due to their caring role.

Unlike other organisations that may provide befriending services, the telephone befriending is likely to be later on in the support required, so by this stage most of the signposting to other organisations has already been completed. It may be that if the carer's situation changes further signposting may be supplied, or they may be referred back to the adult carers' team.

Telephone befrienders provide 'carer-centred' support, by following the carer's conversation and their choice of topic. A carer will be allocated a specific telephone befriender when they first come into the service, so the carer and volunteer befriender can develop a more familiar and comfortable relationship.

We currently have around 150 carers receiving support via the telephone befriending service with approximately 250 calls being made each month. Currently we have 8 telephone befriending

volunteers, who volunteer one day a week, plus an additional volunteer who volunteers on an ad-hoc basis if the need is required, for example due to sickness or holiday.

During the period of the evaluation framework project from 8th May until 9th June 2017, the Befriending Co-ordinator spoke to 6 carers who had been newly referred to the telephone befriending service and recorded the results of the pre-agreed questions. In 1 case it was not possible to complete the questions due to close proximity of cared-for parents close by which made it difficult to talk openly. For the other 5 carers, they were happy to answer the questions. There were no specific trends found in this small sample, however I felt that the question 'I feel part of my local community' was more dependent on where the carer lived rather than their circumstances or related to their caring role.

Please see below a case study for somebody who has been using our telephone befriending service for some time

Case study

David King

When David King's partner of 21 years died in January 2016, he soon became very lonely – until befriending services lifted his spirits. The 78-year-old former boat builder, from Witham, had cared for his beloved Norma Stanfield for the past three years after complications with her legs left her wheelchair bound, before a breast cancer diagnosis led to her passing.

"I used to be able to take her to town in her wheelchair and do the shopping but eventually I couldn't get her in the car on my own," said David, a father of two daughters with three grandchildren. Then her leg seized up in one position which prevented her from getting dressed, so towards the end we had two carers visiting four times a day. So after she died it was very quiet and lonely. But Sue, a befriending volunteer at Action For Family Carers, calls me once a fortnight and we have a chat for about 20 minutes. She's very nice and it's lovely that they phone me up to see how I'm coping. I'm always pleased to hear her voice and I'm sure if there was something I needed they would do their best to help me. I'm very comfortable talking to her because I think she is very understanding."

Age UK Essex

Case study

Name of Service: Home Befriending

Area: South West

Date:

Introduction:

CC has been widowed for 26 years, she has lived in her property in Wickford for over 40 years. CC has two children, both are deceased. CC does not have any family and relies on her carers and her neighbour for her needs. CC is housebound and can only walk with the use of a frame. CC has been matched to a volunteer befriender since March 2014 and they have developed a mutual friendship of trust and respect, the befriender visits CC every week.

Background: the problem being addressed

On the routine monthly monitoring telephone call the befriender raised concerns about CC. The befriender advised that CC was not taking her medication and that CC had three falls in a seven day period, the befriender felt that an investigation into the falls should be carried out.

How did Age UK Essex address these problems?

The befriending coordinator telephoned CC, it was clear from the outset that CC was having trouble hearing on the telephone.

CC advised the coordinator that she is not able to take her medication as she is unable to put the tablets in her mouth due to poor mobility in her arms and hands.

CC became very distressed and advised the coordinator that she has falls in the bathroom when she tries to get on and off the toilet by herself, she said that she does not like to use her call line button to call for help as she is embarrassed, on two occasions an ambulance was called, CC was not hurt and remained at home.

The befriending coordinator contacted The Community Agents and made an urgent referral for CC. The Community Agents were advised of CC's fall and was asked to attend CC at home as soon as possible to complete an adaptations assessment. Within a week CC had a home visit from the Community Agents and adaptations were put into place, a higher toilet seat on a frame with hand rails was fitted in CC's bathroom, and extra grab rails were put around the property where necessary.

The befriending coordinator contacted CC's care company to ask why they were not able to put CC's medication into her mouth. The coordinator was advised by the manager that the carers are not able to do this unless an assessment had been carried out. The befriending coordinator advised that an assessment needed to be carried out as soon as possible as CC had not been taking her medication, which may lead to health implications for CC and could have been a contributing factor to her falls. The assessment took place the next day and CC is now having her medication administered directly to her mouth.

The befriending coordinator also spoke to CC's GP to advise of the current situation and requested for an appointment to the audiology department at the local hospital for CC to have her hearing aids checked.

Did you identify any safeguarding issues?

No safeguarding issues were identified

Who were the key people involved in this case?

The befriending coordinator

The befriending volunteer

The Community Agents

The Care Company

The GP

What was achieved?

CC's medication is now being taken correctly, and the adaptations have been made to CC's home and most importantly her bathroom. CC has not had a fall since this has taken place and she said she feels safe and secure in her own home.

CC has had her hearing aids cleaned and is able to hear more clearly which makes CC able to communicate with her carers, neighbour, coordinator and befriender. CC said she feels much better, is happier and feels like she can engage in conversation which gives her a sense of wellbeing.

If these issues had not been identified by the befriender and without the coordinators intervention CC would have undoubtedly reached critical care and would have been admitted to hospital, so this intervention has reduced the need for NHS services.

What would you do differently next time?

Nothing would have to be done differently

If there are any further questions in regard to the case study, who is the key Age UK Essex Contact?

Age UK Essex contact.

Name: Sarah-Jane Piper

Telephone number: 01268 525353

Mind in West Essex

Case Study

Service User (SU) was an outgoing and confident person. Unfortunately, a few years ago they suffered from a severe stroke which resulted in poor speech and extremely poor mobility. This knocked their confidence as they lost their independence and could no longer go out and do the things they used to enjoy. They felt isolated and lonely. When we first met SU, they had extreme anxiety; they would not answer the telephone unless someone had called and left a message first, would not answer the door to anyone unexpected and would not leave the house. We introduced one of our trained volunteer Befrienders who was a fairly similar age and had the same interests, as they both used to work in hospitals. After our initial meeting together, the Befriender and SU arranged to meet once a week for a couple of hours. We agreed on the action plan to start slowly building up SU's confidence. The first few weeks they talked and got to know each other a bit more, building the SU's speech confidence. Following this, they took a few steps out of the door together with the eventual end goal being to get to the end of the road, which was achieved a few weeks later. The Befriender then encouraged SU to go to a nearby café together. Seven months have now passed and the Befriender and SU go on regular lunch meetings in restaurants and pubs! The Befriender has said that SU is now 'less anxious and more cheerful' and they plan to take a trip together to the town centre. SU has said 'Thank you so much for arranging Befriending. I laugh so much more now and my friends say that I am always smiling'.

Support for Sight

Case study

Beneficiary x is a fifty seven year old male from Chelmsford in Essex.

He is registered Severely Sight impaired, with additional mobility problems and requires dialysis three times a week.

At the beginning of May 2017, beneficiary x was referred internally within Support 4 Sight for our befriending telephone service, as he had very little contact with anyone outside of his limited family circle. He was matched with a volunteer who had a similar visual disability, same gender and similar age bracket for regular telephone calls.

During these calls, an exchange of information was given in respect of the various social events and local coffee mornings. It was arranged that beneficiary x would attend a local coffee event and that the volunteer befriender would meet him there. Beneficiary x enjoyed being part of the event, particularly having the opportunity to meet with other sight impaired peers. He also received information in respect of magnifiers and lighting and he is keen to have an assessment and demonstration to help increase his independence from volunteers during a planned home visit. A date for this is currently being organised.

It was also established that beneficiary x used to be a keen angler, but is no longer able to fish due to his decreasing sight loss. The volunteer befriender has also recently encountered a number of other Severely Sight impaired beneficiaries who also used to fish but who feel that they are no longer able to participate in an angling activity due to their current sight loss. Therefore, a referral has been made to our community services co-ordinator who is negotiating with a local angling club asking for some of their members to help support and mentor several of Support 4 Sights beneficiaries who would like to participate in an angling activity again.

Prior to agreeing to be part of the telephone befriending service, Support 4 Sight had supported beneficiary x with applying for the appropriate benefits and completing paperwork on his behalf. Support 4 Sight had also assisted in referring to ECL for a symbol Cane and had provided beneficiary x with a donated voice activated microwave to enable him to cook and re-heat food.

I feel that Support 4 Sight has given beneficiary x the help and support that he needed to begin his journey to improve his lifestyle and retain some independence, as well as his supporting his emotional and financial wellbeing.